

95 13501

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARTON Estelle ELLIOTT				2. DATE OF DEATH MONTH DAY YEAR APRIL 21, 1995		3. TIME OF DEATH 06:02 M	
4. SOCIAL SECURITY NUMBER 218 56 3598		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 86 YRS.	7. DATE OF BIRTH (Month, Day, Year) Jan. 3, 1909		8. BIRTHPLACE (State or Foreign Country) MD	
9a. FACILITY NAME (If not institution, give street and number) CALVERT MEMORIAL HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH PRINCE FREDERICK		9c. COUNTY OF DEATH CALVERT	
RESIDENCE OF DECEDENT							
10a. STATE MD		10b. COUNTY Calvert		10c. CITY, TOWN OR LOCATION Broome's Island		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 8835 Broome's Island Road				10f. ZIP CODE 20615		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Waitress		16b. KIND OF BUSINESS/INDUSTRY Restaurant			
17. FATHER'S NAME (First, Middle, Last) Luther B Mister				18. MOTHER'S NAME (First, Middle, Maiden Surname) Matilda Suite			
19a. INFORMANT'S NAME (Type/Print) Brice L. Elliott				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8841 Broome's Island Rd., Broome's Is., MD 20615			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Broome's Is. Cemetery Apr. 24, 1995		20c. LOCATION — City or Town, State Broome's Is., MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>W. Michael Appa</i>				22. NAME AND ADDRESS OF FACILITY Rausch Funeral Home, Port Republic, MD 20676			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sepsis							
DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
DUE TO (OR AS A CONSEQUENCE OF):							
DUE TO (OR AS A CONSEQUENCE OF):							
DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Malnutrition - Prolonged Cardiac Arrhythmias							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>M.P. Sharp M.D.</i>				29c. LICENSE NUMBER D-22634		29d. DATE SIGNED (Month, Day, Year) 4-21-95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)							
31. DATE FILED (Month, Day, Year) APR 24 1995				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13502

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Barbara Allen Earnest				2. DATE OF DEATH DAY MONTH YEAR April 19 1995		3. TIME OF DEATH 12:47 P.M.	
4. SOCIAL SECURITY NUMBER 048-24-0266		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 62 YRS.	7. DATE OF BIRTH (Month, Day, Year) Aug 24 1932		8. BIRTHPLACE (State or Foreign Country) Connecticut	
9a. FACILITY NAME (If not institution, give street and number) Anne Arundel Medical Center				9b. CITY, TOWN OR LOCATION OF DEATH Annapolis		9c. COUNTY OF DEATH Anne Arundel	
10a. STATE MD		10b. COUNTY Anne Arundel		10c. CITY, TOWN OR LOCATION Annapolis		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 402 Edgemere Drive				10f. ZIP CODE 21403		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife		16b. KIND OF BUSINESS/INDUSTRY Home			
17. FATHER'S NAME (First, Middle, Last) David Allen				18. MOTHER'S NAME (First, Middle, Maiden Surname) Marion Murphy			
19a. INFORMANT'S NAME (Type/Print) Peter J. Earnest				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 402 Edgemere Drive Annapolis, Maryland 21403			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Ft. Lincoln Crematory 4/23/95		20c. LOCATION — City or Town, State Brentwood, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Donald L. Lyta</i>				22. NAME AND ADDRESS OF FACILITY John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Heart failure 3 months b. coronary artery disease 15 years c. d. Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated event resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes 40 years DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Stuart E. Selouch, MD</i>				29c. LICENSE NUMBER 019838		29d. DATE SIGNED (Month, Day, Year) 4/20/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Stuart E. Selouch, MD 900 Bestgate Rd. Annapolis, MD 21401							
31. DATE FILED (Month, Day, Year) APR 25 1995				32. REGISTRAR'S SIGNATURE <i>John Andrew Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.
1. DECEASED'S NAME (First, Middle, Last) BONITA JEAN EAST					2. DATE OF DEATH MONTH 4 DAY 24 YEAR 95		3. TIME OF DEATH 12:05 P.M.			
4. SOCIAL SECURITY NUMBER 213-62-9679		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 40 42 YRS.		IF UNDER 1 YEAR MONTHS _____ DAYS _____		IF UNDER 24 HRS. HOURS _____ MIN. _____		7. DATE OF BIRTH (Month, Day, Year) 8/18/52 54	
8. BIRTHPLACE (State or Foreign Country) West Virginia										
9a. FACILITY NAME (If not institution, give street and number) Carroll County Gn. Hospital					9b. CITY, TOWN OR LOCATION OF DEATH Westminster			9c. COUNTY OF DEATH Carroll		
RESIDENCE OF DECEASED										
10a. STATE Maryland		10b. COUNTY Carroll		10c. CITY, TOWN OR LOCATION Westminster				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
10e. STREET AND NUMBER 3523 Ellen Drive				10f. ZIP CODE 21157			10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: white		
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) _____				16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife			16b. KIND OF BUSINESS/INDUSTRY n/a			
17. FATHER'S NAME (First, Middle, Last) William Stratton					18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Polly Jenkins					
19a. INFORMANT'S NAME (Type/Print) Philip East Jr.					19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3523 Ellen Drive, Westminster, MD 21157					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Glen Haven Cemetery 4/28/95 DATE			20c. LOCATION — City or Town, State Glen Burnie, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Katherine Pritts - Switzer					22. NAME AND ADDRESS OF FACILITY Pritts Funeral Home & Chapel 412 Washington Rd., Westminster, MD					
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. SEPTIC SHOCK DUE TO (OR AS A CONSEQUENCE OF): b. DISSEMINATED INTRAVASCULAR COAGULATION DUE TO (OR AS A CONSEQUENCE OF): c. WITH FIBRINOLYSIS DUE TO (OR AS A CONSEQUENCE OF): d. _____ Approximate interval Between Onset and Death 48 Approx										
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____ _____ _____										
24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>										
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. SIGNATURE AND TITLE OF CERTIFIER [Signature]					29c. LICENSE NUMBER 239502		29d. DATE SIGNED (Month, Day, Year) 4/26/95			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SYED S. HASAN MD. Carroll Co Gen. Hospital										
31. DATE FILED (Month, Day, Year) APR 27 1995		32. REGISTRAR'S SIGNATURE [Signature]								

95 13504

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) William Granville Eaton				2. DATE OF DEATH MONTH DAY YEAR April 24 1995				3. TIME OF DEATH 1:18 PM	
4. SOCIAL SECURITY NUMBER 220-36-8279		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 86 YRS.		7. DATE OF BIRTH (Month, Day, Year) 6/22/1908		8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not institution, give street and number) 47 West Green Street				9b. CITY, TOWN OR LOCATION OF DEATH Westminster				9c. COUNTY OF DEATH Carroll	
10a. STATE Maryland		10b. COUNTY Carroll		10c. CITY, TOWN OR LOCATION Westminster				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 47 West Green Street				10f. ZIP CODE 21157		10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) teacher		16b. KIND OF BUSINESS/INDUSTRY public schools			
17. FATHER'S NAME (First, Middle, Last) Richard Bascom Eaton				18. MOTHER'S NAME (First, Middle, Maiden Surname) Bessie Weaver					
19a. INFORMANT'S NAME (Type/Print) Brooks Leahy				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 127 E. Main Street, Westminster, MD 21157					
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Carroll Cremations, Inc. 4/26/95		20c. LOCATION — City or Town, State Hampstead, MD					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Katharine Pritts-Sweitzer				22. NAME AND ADDRESS OF FACILITY Pritts Funeral Home & Chapel 412 Washington Rd., Westminster, MD					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → METASTATIC PROSTATE CA DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death 2 1/2 yrs	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER Flavio Kruter MD		29c. LICENSE NUMBER D35398		29d. DATE SIGNED (Month, Day, Year) 4/25/95			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Flavio Kruter - 684A Poole Rd. Westminster, MD 21157									
31. DATE FILED (Month, Day, Year) APR 26 1995				32. REGISTRAR'S SIGNATURE John A. Swisher-Randall					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13505

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>WALTER C EDWARDS</u>				2. DATE OF DEATH MONTH <u>APRIL</u> DAY <u>7</u> YEAR <u>95</u>		3. TIME OF DEATH <u>1900</u> M	
4. SOCIAL SECURITY NUMBER <u>246-52-1309</u>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>59</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>Jan. 17, 1936</u>	
9a. FACILITY NAME (If not institution, give street and number) <u>Washington Adventist Hospital</u>				9b. CITY, TOWN OR LOCATION OF DEATH <u>Takoma Park</u>		9c. COUNTY OF DEATH <u>Montgomery</u>	
10a. STATE <u>Maryland</u>		10b. COUNTY <u>Prince George's</u>		10c. CITY, TOWN OR LOCATION <u>Hyattsville</u>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <u>6315 Balfour Drive</u>				10f. ZIP CODE <u>20782</u>		10g. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>Black</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12th Grade</u> College (1-4 or 5+) <u>College</u>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Chauffeur/with the CIA</u>		16b. KIND OF BUSINESS/INDUSTRY <u>Government</u>			
17. FATHER'S NAME (First, Middle, Last) <u>Walter D. Edwards</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Rosetta Edwards</u>			
19a. INFORMANT'S NAME (Type/Print) <u>Geraldine H. Edwards/Wife</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>6315 Balfour Drive Hyattsville, Maryland 20782</u>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Harmony Memorial Park</u>		DATE <u>4-7</u>		20c. LOCATION — City or Town, State <u>Landover, Maryland</u>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Quana L. Braxton</u>				22. NAME AND ADDRESS OF FACILITY <u>J.B. Jenkins Funeral 7474 Landover Road, Landover, MD 20785</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <u>Metastatic small cell ca of the lung</u>					Approximate Interval Between Onset and Death <u>6 weeks</u>
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. <u>Massive Liver Metastasis</u>					<u>6 weeks</u>
		c. <u>Liver failure</u>					<u>6 days</u>
		d. <u>Dehydration</u>					<u>3 days</u>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <u>M</u>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <u>Charles L. Franklin Jr.</u>				29c. LICENSE NUMBER <u>D14404</u>		29d. DATE SIGNED (Month, Day, Year) <u>4-7-95</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>Charles L. Franklin Jr. 11120 New Hampshire Ave Silver Spring MD 20904</u>							
31. DATE FILED (Month, Day, Year) <u>APR 11 1995</u>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13506

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Mary Ann Edwards				2. DATE OF DEATH MONTH DAY YEAR April 21, 1995		3. TIME OF DEATH a ^m 6:00	
4. SOCIAL SECURITY NUMBER 247 - 76 - 2503		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 52 YRS.		7. DATE OF BIRTH (Month, Day, Year) Apr 30, 1942	
8. BIRTHPLACE (State or Foreign Country) South Carolina				9a. FACILITY NAME (If not institution, give street and number) Manor Care Nursing and Rehab. Center		9b. CITY, TOWN OR LOCATION OF DEATH Largo	
9c. COUNTY OF DEATH Prince George				10a. STATE Maryland		10b. COUNTY Prince George	
10c. CITY, TOWN OR LOCATION New Carrollton				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 5913 85th Place	
10f. ZIP CODE 20784				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4 Years College (1-4 or 5+) 4 Years				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Social Worker		16b. KIND OF BUSINESS/INDUSTRY Department of Social Service	
17. FATHER'S NAME (First, Middle, Last) Rubin Cuffie				18. MOTHER'S NAME (First, Middle, Maiden Surname) Louise Ridges			
19a. INFORMANT'S NAME (Type/Print) Tina R. Martin				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1501 Baytree Terrace, Mitchellville, MD 20721			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Greenlawn Cemetery		20c. LOCATION — City or Town, State 4/25 Hartsville, S.C.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Maryland 20707			
23. PART I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Breast Cancer DUE TO (OR AS A CONSEQUENCE OF): a. Metastatic Cancer DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dehydration							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Sam Tellawi</i>				29c. LICENSE NUMBER 034274		29d. DATE SIGNED (Month, Day, Year) 4-21-95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Sam Tellawi, M.D. 4000 Mitchellville Road Suite A112, Bowie, Maryland 20716							
31. DATE FILED (Month, Day, Year) APR 27 1995				32. REGISTRAR'S SIGNATURE <i>Julia Davidson Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Amended # 208, 4/24/95, SW, Calvert Co.

95 13507

1 -
FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

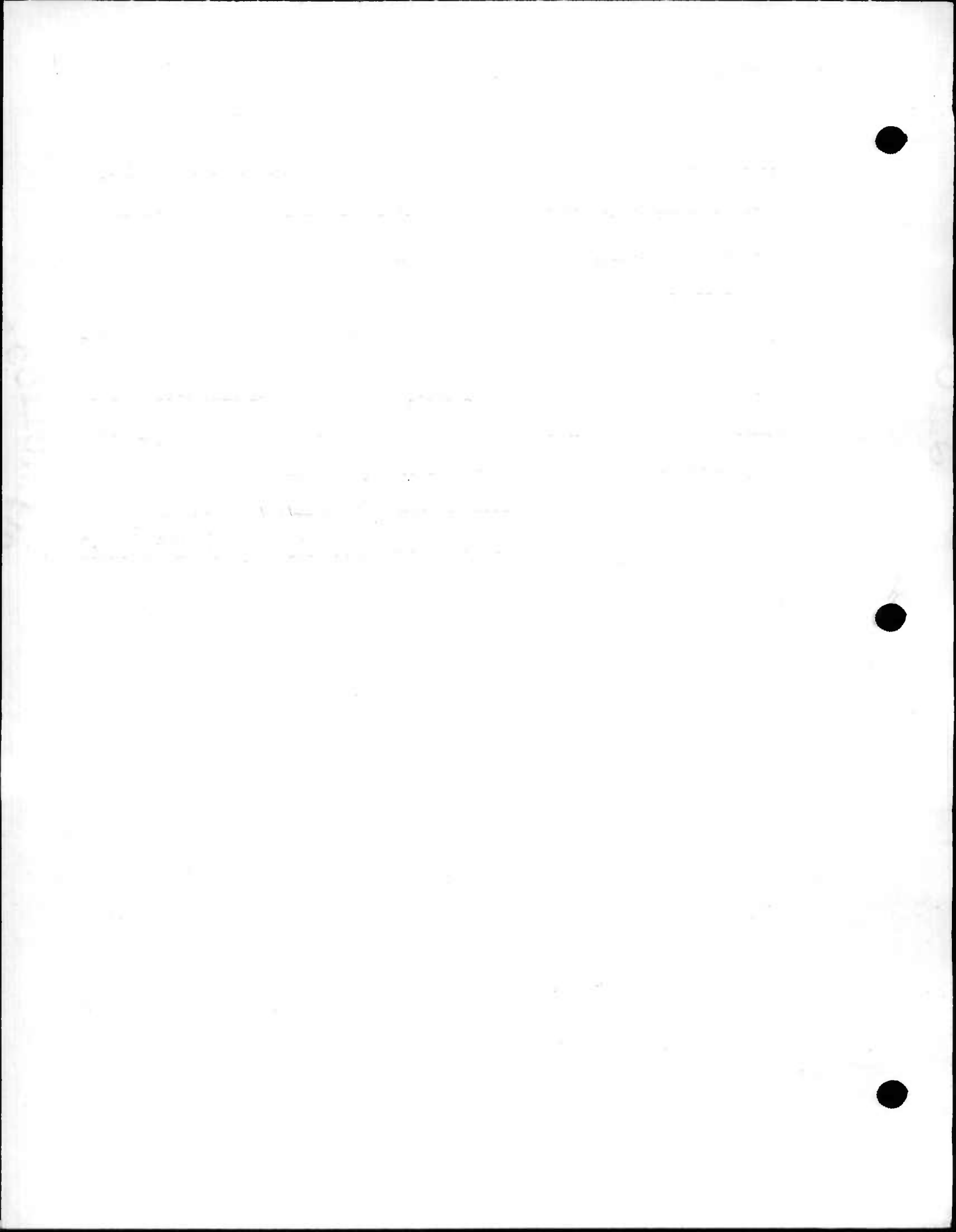
1. DECEDENT'S NAME (First, Middle, Last) Ada Franklin				2. DATE OF DEATH April 18, 1995		3. TIME OF DEATH 2030	
4. SOCIAL SECURITY NUMBER 213-34-5240		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (in yrs. last birthday) 78 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 14, 1916	
8. BIRTHPLACE (State or Foreign Country) Maryland		9a. FACILITY NAME (If not institution, give street and number) Calvert Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Prince Frederick		9c. COUNTY OF DEATH Calvert	
10a. STATE Maryland				10b. COUNTY Calvert		10c. CITY, TOWN OR LOCATION Dunkirk	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 9798 Howes Road		10f. ZIP CODE 20754	
10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:	
14. RACE — American Indian, Black, White, etc. Specify: Black		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Domestic		16b. KIND OF BUSINESS/INDUSTRY Someone else's home	
17. FATHER'S NAME (First, Middle, Last) George Evans				18. MOTHER'S NAME (First, Middle, Maiden Surname) Annie Mitchell			
19a. INFORMANT'S NAME (Type/Print) Annie Rawlings				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9798 Howes Rd. Dunkirk, MD 20754			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Moses Cemetery 4/24 - 4/4/95		20c. LOCATION — City or Town, State Lothian, MD		20d. DATE 4/24/95	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Spencer E. Sewell				22. NAME AND ADDRESS OF FACILITY Sewell Funeral Home 1451 Dares Beach Rd. Prince Frederick, MD			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Progressive Alzheimer's Disease DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cerebrovascular Accident							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Dr. Jonathon Lowenthal				29c. LICENSE NUMBER 033723		29d. DATE SIGNED (Month, Day, Year) 4-20-95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Jonathon Lowenthal Prince Frederick, MD 20678							
31. DATE FILED (Month, Day, Year) APR 21 1995				32. REGISTRAR'S SIGNATURE John Davidson Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020


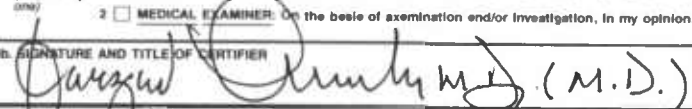
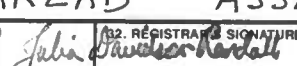
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 13508

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) EVA FLICKINGER				2. DATE OF DEATH MONTH 04 DAY 25 YEAR 95		3. TIME OF DEATH 2:25 am	
4. SOCIAL SECURITY NUMBER 213-16-9296		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 84 YRS.		7. DATE OF BIRTH (Month, Day, Year) Sept. 28, 1910	
9a. FACILITY NAME (If not institution, give street and number) Westminster Nursing & Conv. Ctr.				9b. CITY, TOWN OR LOCATION OF DEATH Westminster		9c. COUNTY OF DEATH Carroll	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Carroll		10c. CITY, TOWN OR LOCATION Westminster		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 73 Pennsylvania Ave				10f. ZIP CODE 21157		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+) College				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Assembly		16b. KIND OF BUSINESS/INDUSTRY Manufactory	
17. FATHER'S NAME (First, Middle, Last) Charles Dull				18. MOTHER'S NAME (First, Middle, Maiden Surname) Emma Grace Gamber			
19a. INFORMANT'S NAME (Type/Print) June A. Borchers				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 1081, Bethany, Okla. 73008			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) St. John's Cemetery		DATE 4/27		20c. LOCATION — City or Town, State Westminster, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Fletcher Funeral Home 254 E. Main St. Westminster, Md.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. Acute respiratory failure → Cessation of respiration.					Approximate Interval Between Onset and Death started @ 2:00 AM Ended @ 2:25 AM on 4-25-95
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST		b. Metabolic Encephalopathy					
		c. Subacute Hepatic Failure.					
		d. Multi-organ failure including CHF.					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. other conditions, interstitial lung disease, valvular Heart disease. Advanage.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER  (M.D.)				29c. LICENSE NUMBER D-40201		29d. DATE SIGNED (Month, Day, Year) 4-25-95 9:30 AM	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) FARZAD ASSAR, M.D. 1502 S. MAIN ST. MT AIRY 21771							
31. DATE FILED (Month, Day, Year) APR 25 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13509

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

4-22-95 11:25AM

1. DECEDENT'S NAME (First, Middle, Last) LAWRENCE Lawrence Vernon Freeman Jr. FREEMAN				2. DATE OF DEATH MONTH 4 DAY 22 YEAR 95		3. TIME OF DEATH 11 25 A M	
4. SOCIAL SECURITY NUMBER 218-12-9687		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		8. AGE (In yrs. last birthday) 70 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 29 1924	
9a. FACILITY NAME (If not institution, give street and number) Anne Arundel Medical Center		9b. CITY, TOWN OR LOCATION OF DEATH Annapolis				9c. COUNTY OF DEATH Anne Arundel	
RESIDENCE OF DECEDENT							
10a. STATE MD		10b. COUNTY Anne Arundel		10c. CITY, TOWN OR LOCATION Annapolis		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 7 Spruce Lane				10f. ZIP CODE 21401		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Stockman		16b. KIND OF BUSINESS/INDUSTRY US Naval Academy	
17. FATHER'S NAME (First, Middle, Last) Lawrence V. Freeman				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Agnes Trott			
19a. INFORMANT'S NAME (Type/Print) Millie Ann Freeman				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7 Spruce Lane Annapolis, Maryland 21401			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Maryland Veterans Cemetery		DATE 4/25/95		20c. LOCATION — City or Town, State Crownsville, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Donald S. Taylor</i>				22. NAME AND ADDRESS OF FACILITY John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Diabetes mellitus DUE TO (OR AS A CONSEQUENCE OF): Hypertension DUE TO (OR AS A CONSEQUENCE OF): Chronic renal failure DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. retinopathy							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>David S. McHold M.D.</i>				29c. LICENSE NUMBER D07327		29d. DATE SIGNED (Month, Day, Year) 4/22/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) David S. McHold, M.D. 116 Defense Hwy. #200 Annapolis, MD 21401 (410-224-2414)							
31. DATE FILED (Month, Day, Year) APR 25 1995				32. REGISTRAR'S SIGNATURE <i>Julia Davidson Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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95 13510

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Everett R. Ford				2. DATE OF DEATH MONTH DAY YEAR April 11, 1995		3. TIME OF DEATH 12:20 p. M	
4. SOCIAL SECURITY NUMBER 578-10-4603		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 79 YRS.		7. DATE OF BIRTH (Month, Day, Year) 10/9/15	
8. BIRTHPLACE (State or Foreign Country) Virginia				9a. FACILITY NAME (If not institution, give street and number) Western Maryland Center		9b. CITY, TOWN OR LOCATION OF DEATH Hagerstown	
9c. COUNTY OF DEATH Washington				10a. STATE Maryland		10b. COUNTY Washington	
10c. CITY, TOWN OR LOCATION Boonsboro				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 213 South Gate Dr.	
10f. ZIP CODE 21713		10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Deliveryman		16b. KIND OF BUSINESS/INDUSTRY Milk			
17. FATHER'S NAME (First, Middle, Last) Everett P. Ford				18. MOTHER'S NAME (First, Middle, Maiden Surname) Hazel Rye			
19a. INFORMANT'S NAME (Type/Print) Thelma E. Ford				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) same as item 10			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Washington National Cem. 4/14/95		20c. LOCATION — City or Town, State Suitland, Md.		21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>George P. Kalas Jr.</i>	
22. NAME AND ADDRESS OF FACILITY George P. Kalas Funeral Home 6160 Oxon Hill Rd. Oxon Hill, Md. 20745				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Sepsis DUE TO (OR AS A CONSEQUENCE OF): b. Peritonitis DUE TO (OR AS A CONSEQUENCE OF): c. End-stage renal disease on continuous ambulatory peritoneal dialysis DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Congestive heart failure, coronary artery disease				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Fe U. Porciuncula</i>				29c. LICENSE NUMBER D12642		29d. DATE SIGNED (Month, Day, Year) April 11, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Fe U. Porciuncula, M.D. 1500 Pennsylvania Ave., Hagerstown, MD 21742							
31. DATE FILED (Month, Day, Year) APR 12 1995				32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>			

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

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TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

95 13511

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Alice Marie FLOOK				2. DATE OF DEATH MONTH DAY YEAR April 21, 1995		3. TIME OF DEATH 0340	
4. SOCIAL SECURITY NUMBER 220-18-0242		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 75 YRS.		7. DATE OF BIRTH (Month, Day, Year) Oct. 13, 1919	
8. BIRTHPLACE (State or Foreign Country) Virginia				9a. FACILITY NAME (If not institution, give street and number) Frederick Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Frederick	
9c. COUNTY OF DEATH Frederick				10a. STATE Maryland		10b. COUNTY Frederick	
10c. CITY, TOWN OR LOCATION Frederick				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 108 Frederick Avenue	
10f. ZIP CODE 21701				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) College				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Assembly lineperson		16b. KIND OF BUSINESS/INDUSTRY Optical company	
17. FATHER'S NAME (First, Middle, Last) Lewellyn L. Whittington				18. MOTHER'S NAME (First, Middle, Maiden Surname) Nettie Elizabeth Burke			
19a. INFORMANT'S NAME (Type/Print) Carol E. Whittington				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 108 Frederick Ave., Frederick, Maryland 21701			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Resthaven Memorial Gardens Apr. 24, 1995 Frederick, Md.		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Richard C. C. Buford</i> M00021				22. NAME AND ADDRESS OF FACILITY Keeney and Basford Funeral Home 105 East Church Street, Frederick, Md. 21701			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → ASCVD Sequitently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate Interval Between Onset and Death 3y11	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURRED					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Julio Menocal</i>		29c. LICENSE NUMBER D-31912		29d. DATE SIGNED (Month, Day, Year) 4/24/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Julio Menocal, M.D., Parkview Medical Center, Frederick, Maryland 21701							
31. DATE FILED (Month, Day, Year) APR 24 1995				32. REGISTRAR'S SIGNATURE <i>John Andrew Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) GEORGE KIM FRICK				2. DATE OF DEATH MONTH DAY YEAR April 15, 1995		3. TIME OF DEATH 02:50 A M	
4. SOCIAL SECURITY NUMBER 173-12-5505		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 78 YRS.		7. DATE OF BIRTH (Month, Day, Year) APRIL 28 1916	
8. BIRTHPLACE (State or Foreign Country) PA.				9a. FACILITY NAME (If not institution, give street and number) Memorial Hospital & Medical Center		9b. CITY, TOWN OR LOCATION OF DEATH Cumberland	
9c. COUNTY OF DEATH Allegany				10a. STATE MARYLAND		10b. COUNTY ALLEGANY	
10c. CITY, TOWN OR LOCATION LAVALE				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 607 NORTH FIRST STREET	
10f. ZIP CODE 21502		10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: WHITE			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12+ 4 College (1-4 or 5+) 4		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CHIEF CHEMIST		16b. KIND OF BUSINESS/INDUSTRY KELLY SPRINGFIELD TIRE CO.			
17. FATHER'S NAME (First, Middle, Last) GEORGE D. FRICK				18. MOTHER'S NAME (First, Middle, Maiden Surname) CATHERINE KIM			
19a. INFORMANT'S NAME (Type/Print) WILMA FRICK				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 607 NORTH FIRST STREET LAVALE, MARYLAND 21502			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) CUMBERLAND CREMATORY APRIL 16 1995 CUMBERLAND MARYLAND		20c. LOCATION — City or Town, State		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Dale L. Merritt</i>				22. NAME AND ADDRESS OF FACILITY MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Ischemic Cardiac arrest</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>Coronary atherosclerosis</i> DUE TO (OR AS A CONSEQUENCE OF): <i>78 years</i>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Pending Investigation 3 <input type="checkbox"/> Accident 4 <input type="checkbox"/> Suicide 5 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. W. Guy Fiscus</i>		29c. LICENSE NUMBER D12719		29d. DATE SIGNED (Month, Day, Year) APR 15, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. W. Guy Fiscus Memorial Hospital Medical Bldg., 500 Memorial Ave., Cumberland MD. 21502							
31. DATE FILED (Month, Day, Year) APR 17 1995				32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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95 13513

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Madeline C. Fletcher				2. DATE OF DEATH MONTH April DAY 07 YEAR 1995				3. TIME OF DEATH 12:01 a.m.			
4. SOCIAL SECURITY NUMBER 220-10-7546		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 73 YRS.		7. DATE OF BIRTH (Month, Day, Year) Apr. 17, 1921		8. BIRTHPLACE (State or Foreign Country) MARYLAND			
9a. FACILITY NAME (If not Institution, give street and number) WESTERN MARYLAND CENTER						9b. CITY, TOWN OR LOCATION OF DEATH HAGERSTOWN			9c. COUNTY OF DEATH WASHINGTON		
RESIDENCE OF DECEDENT											
10a. STATE MARYLAND		10b. COUNTY ALLEGANY		10c. CITY, TOWN OR LOCATION CRESAPTOWN				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STREET AND NUMBER 1000 HAROLD DRIVE				10f. ZIP CODE 21502		10g. CITIZEN OF WHAT COUNTRY? U.S.A.					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> 2				15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) REGISTERED NURSE				15b. KIND OF BUSINESS/INDUSTRY NURSING			
17. FATHER'S NAME (First, Middle, Last) DEWEY SHEPHERD						18. MOTHER'S NAME (First, Middle, Maiden Surname) MARGARET SHANHOLTZ					
19a. INFORMANT'S NAME (Type/Print) PAUL FLETCHER				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12 PARSON AVE.-BLOOMINGTON, MD 21523							
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) CUMBERLAND CREMATORY DATE 4/9/95				20c. LOCATION — City or Town, State CUMBERLAND, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Charles G. Ypochence</i>				22. NAME AND ADDRESS OF FACILITY GEORGE-UPCHURCH FUNERAL HOME, P.A. 202 GREENE ST., CUMBERLAND, MD 21502							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Pneumonia										Approximate Interval Between Onset and Death 4/5/95	
DUE TO (OR AS A CONSEQUENCE OF):											
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST											
b. End-stage COPD - Ventilator Dependent										6 years	
DUE TO (OR AS A CONSEQUENCE OF):											
c. DUE TO (OR AS A CONSEQUENCE OF):											
d. DUE TO (OR AS A CONSEQUENCE OF):											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cerebrovascular accident, Seizure, Pagets Disease, Osteoporosis											
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>										24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
										24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Fe U. Porciuncula M.D.</i>						29c. LICENSE NUMBER D12642		29d. DATE SIGNED (Month, Day, Year) April 07, 1995			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Fe U. Porciuncula, M.D. 1500 Pennsylvania Ave., Hagerstown, MD 21742											
31. DATE FILED (Month, Day, Year) APR 12 1995				32. REGISTRAR'S SIGNATURE <i>John A. Marshall</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13514

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Lawrence Green</i>				2. DATE OF DEATH MONTH DAY YEAR <i>April 8 1995</i>		3. TIME OF DEATH <i>9:57 P.M.</i>	
4. SOCIAL SECURITY NUMBER <i>215-20-0485</i>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <i>68</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7. DATE OF BIRTH (Month, Day, Year) <i>May 28 1926</i>				8. BIRTHPLACE (State or Foreign Country) <i>Maryland</i>			
9a. FACILITY NAME (If not institution, give street and number) <i>Arundel Medical Center</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Annapolis</i>		9c. COUNTY OF DEATH <i>Anne Arundel</i>	
RESIDENCE OF DECEDENT							
10a. STATE <i>Maryland</i>		10b. COUNTY <i>Chester</i>		10c. CITY, TOWN OR LOCATION <i>Riverside</i>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <i>211 Riverside Drive</i>				10f. ZIP CODE <i>21619</i>		10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <i>July 45 - August 46</i>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No - If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE - American Indian, Black, White, etc. Specify: <i>Afro-American</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <i>Elementary/Secondary (0-12)</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Waterman</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Self Employed</i>			
17. FATHER'S NAME (First, Middle, Last) <i>William Green</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Lucille Smith</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Evelyn Green</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>211 Riverside Drive Chester, Maryland 21619</i>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Union Wesleyan UMC Cemetery</i>		20c. LOCATION - City or Town, State <i>Chester, Maryland</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Jeff Miller</i>				22. NAME AND ADDRESS OF FACILITY <i>Jeff miller F/H P.C. 21213</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
a. <i>Acute Respiratory Obstruction</i> 4 Days							
b. <i>Poor Swallowing Ability</i> 7 Months							
c. <i>CVA</i> 7 Months							
d. <i>Respiratory Arrest</i> 4 Days							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Barbara L. Bean MD</i>				29c. LICENSE NUMBER <i>D39497</i>		29d. DATE SIGNED (Month, Day, Year) <i>4/24/95</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Barbara L. Bean MD Suite 300 900 Bestgate Road, Annapolis 21401 Maryland</i>							
31. DATE FILED (Month, Day, Year) <i>APR 26 1995</i>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95-2379-035
B.K.S

95 13515

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) ROBERT GEORGE GATES JR.						2. DATE OF DEATH MONTH DAY YEAR APRIL 23, 1995		3. TIME OF DEATH 5:15P M			
4. SOCIAL SECURITY NUMBER 577-90-0061		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 36 YRS.		7. DATE OF BIRTH (Month, Day, Year) Sept 11 1958		8. BIRTHPLACE (State or Foreign Country) Kansas			
9a. FACILITY NAME (If not institution, give street and number) E/B BAY BRIDGE				9b. CITY, TOWN OR LOCATION OF DEATH Stevensville				9c. COUNTY OF DEATH QUEEN ANNES			
10a. STATE MD		10b. COUNTY Anne Arundel		10c. CITY, TOWN OR LOCATION Pasadena				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 103 Willobrook Drive				10f. ZIP CODE 21122		10g. CITIZEN OF WHAT COUNTRY? United States					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12				16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Manager		16b. KIND OF BUSINESS/INDUSTRY Food Industry					
17. FATHER'S NAME (First, Middle, Last) Robert G. Gates, Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Garyfalia Hatzegeorgiou							
19a. INFORMANT'S NAME (Type/Print) Catherine M. Gates				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 103 Willobrook Drive Pasadena, Maryland 21122							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) St. Demetrius Cemetery 4/26/95		20c. LOCATION — City or Town, State Annapolis, Maryland							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD							
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Drowning Complicating Chest Injuries</i> DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) BAY BRIDGE									
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 3/26/95		28b. TIME OF INJURY 2043M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED <i>Subject jumped off Bridge</i>			
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <i>bridge</i>				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <i>East End of Chesapeake Bay Bridge</i>					
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Theodore M. King MD</i>						29c. LICENSE NUMBER O.C.M.E		29d. DATE SIGNED (Month, Day, Year) APRIL 24, 1995			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Theodore M King</i> 111 Penn Street, Baltimore, Maryland 21201											
31. DATE FILED (Month, Day, Year) APR 27 1995						32. REGISTRAR'S SIGNATURE <i>Julia Davidson Randall</i>					

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

95 13516

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Lillian B. Giles				2. DATE OF DEATH MONTH April DAY 24 YEAR 1995				3. TIME OF DEATH 9:50 A.M.	
4. SOCIAL SECURITY NUMBER 215-12-9028		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 74 YRS.		7. DATE OF BIRTH (Month, Day, Year) 4-7-21		8. BIRTHPLACE (State or Foreign Country) MARYLAND	
9a. FACILITY NAME (If not institution, give street and number) North Arundel Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Glen Burnie				9c. COUNTY OF DEATH Anne Arundel	
10a. STATE MARYLAND		10b. COUNTY ANNE ARUNDEL		10c. CITY, TOWN OR LOCATION SEVERNA PARK				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 371 RITCHIE HIGHWAY				10f. ZIP CODE 21146		10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7th College (14 or 5+) CUSTODIAN				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CUSTODIAN		16b. KIND OF BUSINESS/INDUSTRY ANNE ARUNDEL COMMUNITY COLLEGE			
17. FATHER'S NAME (First, Middle, Last) CHARLES I. CARR				18. MOTHER'S NAME (First, Middle, Maiden Surname) ESTHER MORGAN					
19a. INFORMANT'S NAME (Type/Print) VIRGINIA WHITE				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. BOX 11934 BALTIMORE, MD. 21207					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) ASBURY TOWNNECK CHURCH CEME. 4/29/95 SEVERNA PK., MD.		20c. LOCATION — City or Town, State					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Lillian Giles				22. NAME AND ADDRESS OF FACILITY REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401					
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sub arachnoid hemorrhage MASSIVE SUBDURAL HEMATOMA DUE TO (OR AS A CONSEQUENCE OF): HYPERTENSION Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF):								Approximate Interval Between Onset and Death 1 week many years	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ANEMIA								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO								DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER Medical House Officer		29c. LICENSE NUMBER D43977		29d. DATE SIGNED (Month, Day, Year) April 24th 95			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type, Print) OKETUNJI, APRIL 24th HOSP. DRIVE (N.A.H.) GLEN BURNIE MD. 21061									
31. DATE FILED (Month, Day, Year) APR 27 1995		32. REGISTRAR'S SIGNATURE Julia Dawson-Randall							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13517

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Gertrude L Gellatly</i>				2. DATE OF DEATH <i>MARCH 31, 1995</i> YEAR				3. TIME OF DEATH <i>6:23P</i> M	
4. SOCIAL SECURITY NUMBER <i>579-18-4047</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>76</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) <i>Jan. 19, 1919</i>	
8. BIRTHPLACE (State or Foreign Country) <i>Maryland</i>				9a. FACILITY NAME (If not Institution, give street and number) <i>Doctor's Community Hospital</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Lanham</i>	
9c. COUNTY OF DEATH <i>Prince George's</i>				10a. STATE <i>Maryland</i>				10b. COUNTY <i>Prince George's</i>	
10c. CITY, TOWN OR LOCATION <i>Greenbelt</i>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <i>7010 Greenbelt Road</i>	
10f. ZIP CODE <i>20770</i>				10g. CITIZEN OF WHAT COUNTRY? <i>United States</i>				11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i></i>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Administrative Assistant</i>				16b. KIND OF BUSINESS/INDUSTRY <i>Church</i>	
17. FATHER'S NAME (First, Middle, Last) <i>Leroy M. Laughton</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Elizabeth Herberger</i>					
19a. INFORMANT'S NAME (Type/Print) <i>Ronald E. Gellatly</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>5923 Berwyn Road, Berwyn Heights, Maryland 20740</i>					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Fort Lincoln Cemetery 4/5/95</i>				20c. LOCATION — City or Town, State <i>Brentwood, Maryland</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Mark A. Yeckley</i>				22. NAME AND ADDRESS OF FACILITY <i>Fort Lincoln Funeral Home, Inc. 3401 Bladensburg Rd., Brentwood, MD 20722</i>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>a. Terminal Cancer of Liver</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>b. Colon Cancer with Metastasis</i> DUE TO (OR AS A CONSEQUENCE OF): <i>c.</i> DUE TO (OR AS A CONSEQUENCE OF): <i>d.</i>								Approximate Interval Between Onset and Death <i>3 years</i> <i>3 years</i>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Paroxysmal Atrial Fibrillation</i>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO								DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. Tsunie Chanchien M.D. FACP</i>				29c. LICENSE NUMBER <i>D13339</i>	
29d. DATE SIGNED (Month, Day, Year) <i>4/3/95</i>				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Dr. Tsunie Chanchien 8824 Cunningham Drive Berwyn Heights, MD 20740</i>					
31. DATE FILED (Month, Day, Year) <i>APR 10 1995</i>				32. SIGNATURE OF REGISTRAR <i>John A. ...</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13518

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Doris Jean Gooding</i>				2. DATE OF DEATH MONTH DAY YEAR <i>April 8, 1995</i>				3. TIME OF DEATH M <i>8:00</i>	
4. SOCIAL SECURITY NUMBER <i>577-64-2110</i>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>48</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>June 24, 1946</i>		8. BIRTHPLACE (State or Foreign Country) <i>Mississippi</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>8623 Annapolis Road, #102</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>New Carrollton</i>				9c. COUNTY OF DEATH <i>Prince George's</i>	
RESIDENCE OF DECEDENT									
10a. STATE <i>Maryland</i>		10b. COUNTY <i>Prince George's</i>		10c. CITY, TOWN OR LOCATION <i>New Carrollton</i>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <i>8623 Annapolis Road, #102</i>				10f. ZIP CODE <i>20784</i>		10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>10</i> College (1-4 or 5+) <i></i>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Homemaker</i>			16b. KIND OF BUSINESS/INDUSTRY <i>Own Home</i>		
17. FATHER'S NAME (First, Middle, Last) <i>Louis Nichols</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Doris Jones</i>					
19a. INFORMANT'S NAME (Type/Print) <i>Betty Ajmani</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>6131 Summer Park Lane, Alexandria, Virginia 22310</i>					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Fort Lincoln Cemetery 4/11/95</i>			20c. LOCATION — City or Town, State <i>Brentwood, Maryland</i>		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>H. Constance Gasch</i>				22. NAME AND ADDRESS OF FACILITY <i>Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781</i>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Hypertensive intervascular cardiac disease</i> DUE TO (OR AS A CONSEQUENCE OF): Sequitely ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.									Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Depression, Seizures</i>									24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO									
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Augusto P. Rodriguez MD</i>				29c. LICENSE NUMBER <i>21230</i>		29d. DATE SIGNED (Month, Day, Year) <i>April 8, 1995</i>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Augusto P. Rodriguez MD, 5009 Rayburn Ct. Sp. Md 20748</i>									
31. DATE FILED (Month, Day, Year) <i>APR 13 1995</i>				32. REGISTRAR'S SIGNATURE <i>Julia Shuler-Karroll</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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95 13519

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Catherine E. Milstead Graybeal				2. DATE OF DEATH April 6, 1995		3. TIME OF DEATH 11:15A	
4. SOCIAL SECURITY NUMBER 231-68-4415		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 46	7. DATE OF BIRTH 12/12/48		8. BIRTHPLACE (State or Foreign Country) Washington, D.C.	
9a. FACILITY NAME (If not institution, give street and number) Holy Cross Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring		9c. COUNTY OF DEATH Montgomery	
10a. STATE Maryland		10b. COUNTY Prince George's		10c. CITY, TOWN OR LOCATION Upper Marlboro		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 1102 Dixie Bowie Way				10f. ZIP CODE 20772		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11th College (1-4 or 5+) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Supervisor		16b. KIND OF BUSINESS/INDUSTRY U.S. Postal Service			
17. FATHER'S NAME (First, Middle, Last) Richard W. Milstead				18. MOTHER'S NAME (First, Middle, Maiden Surname) Hazel I. Hayes			
19a. INFORMANT'S NAME (Type/Print) Judy I. Savage				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12701 Sesame Seed Ct. Germantown, Md. 20874			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metropolitan Crematory 4/10/95		20c. LOCATION — City or Town, State Alexandria, Va.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>George P. Kalas</i>				22. NAME AND ADDRESS OF FACILITY George P. Kalas Funeral Home 6160 Oxon Hill Rd. Oxon Hill, Md. 20745			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → s. <u>Cardiopulmonary Arrest</u> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { b. <u>Alcoholic Liver Disease</u> DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Veronica Jenkins</i>				29c. LICENSE NUMBER D39973		29d. DATE SIGNED (Month, Day, Year) 4/6/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Veronica Jenkins, M.D. 6104 Old Branch Ave. Temple Hills, Md. 20746							
31. DATE FILED (Month, Day, Year) APR 10 1995				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13520

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) (A.K.A. Mabel Catherine Gude) Catherine Mabel Gude				2. DATE OF DEATH MONTH DAY YEAR April 7, 1995		3. TIME OF DEATH 6:00 P M	
4. SOCIAL SECURITY NUMBER 220-56-6613		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 90 YRS.		7. DATE OF BIRTH (Month, Day, Year) Jan. 30, 1905	
8. BIRTHPLACE (State or Foreign Country) Maryland		9. FACILITY NAME (If not institution, give street and number) Carriage Hill Nursing Center		9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring		9c. COUNTY OF DEATH Montgomery	
10a. STATE Maryland		10b. COUNTY Prince George's		10c. CITY, TOWN OR LOCATION Adelphi		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 1722 Keokee Street		10f. ZIP CODE 20783		10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) 6		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) James Arthur Charles				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Eleanor Schulze			
19a. INFORMANT'S NAME (Type/Print) Betty F. Radisch				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1722 Keokee Street, Adelphi, Maryland 20783			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Rock Creek Cemetery 4/11/95		20c. LOCATION — City or Town, State Washington, D.C.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Francis Gasch				22. NAME AND ADDRESS OF FACILITY Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Congestive Heart Failure DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death 10 yrs
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Mark A. Eig				29c. LICENSE NUMBER D 24886		29d. DATE SIGNED (Month, Day, Year) 4/10/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Mark A. Eig, M.D. 9801 Georgia Avenue Silver Spring MD							
31. DATE FILED (Month, Day, Year) APR 13 1995				32. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13521

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) SOL S. GLICKSMAN				2. DATE OF DEATH MONTH DAY YEAR April 16, 1995		3. TIME OF DEATH 2:54 P M	
4. SOCIAL SECURITY NUMBER 100-07-6443		5. SEX 1 M 2 F		6. AGE (In yrs. last birthday) 83 YRS.		7. DATE OF BIRTH (Month, Day, Year) Nov. 16, 1911	
8. BIRTHPLACE (State or Foreign Country) Poland				9a. FACILITY NAME (If not Institution, give street and number) Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Cumberland	
9c. COUNTY OF DEATH Allegany				10a. STATE Maryland		10b. COUNTY Allegany	
10c. CITY, TOWN OR LOCATION Cumberland				10d. INSIDE CITY LIMITS? 1 X YES 2 NO		10e. STREET AND NUMBER 16 N. Allegany Street	
10f. ZIP CODE 21502				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 X Never Married 2 Married 3 Widowed 4 Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: White				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) Unknown			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Manager				16b. KIND OF BUSINESS/INDUSTRY Undergarment Factory			
17. FATHER'S NAME (First, Middle, Last) Aron David Glicksman				18. MOTHER'S NAME (First, Middle, Maiden Surname) Tauba			
19a. INFORMANT'S NAME (Type/Print) Frances Glicksman				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16 N. Allegany St-Cumberland, MD 21502			
20a. METHOD OF DISPOSITION 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Eastview Cemetery 4/19/95			
20c. LOCATION — City or Town, State Cumberland, MD				21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Stena G. Yachnick</i>			
22. NAME AND ADDRESS OF FACILITY George-Upchurch Funeral Home, P.A. 202 Greene St., Cumberland, MD 21502				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Congestive Heart Failure DUE TO (OR AS A CONSEQUENCE OF): b. Renal Failure DUE TO (OR AS A CONSEQUENCE OF): c. Coronary Artery Disease DUE TO (OR AS A CONSEQUENCE OF): d.			
Approximate interval Between Onset and Death 5 Years 4 Years 10 Years				PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Mellitus			
24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN X				25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO			
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify)				27. MANNER OF DEATH 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined			
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY M			
28c. INJURY AT WORK? 1 YES 2 NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. Vik Poonai</i>			
29c. LICENSE NUMBER D 36766				29d. DATE SIGNED (Month, Day, Year) April 19, 1995			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Vik Poonai, 955 Frederick Street, Cumberland, MD 21502				31. DATE FILED APR 19 1995			
32. REGISTRAR'S SIGNATURE <i>John A. Hardall</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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95 13522

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Louise GILLARD		2. DATE OF DEATH MONTH DAY YEAR April 22, 1995		3. TIME OF DEATH 3:05 P. M.	
4. SOCIAL SECURITY NUMBER 214-52-6891		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 76 YRS.	
7. DATE OF BIRTH (Month, Day, Year) May 6, 1918		8. BIRTHPLACE (State or Foreign Country) Texas			
9a. FACILITY NAME (If not institution, give street and number) Asbury Village		9b. CITY, TOWN OR LOCATION OF DEATH Gaithersburg		9c. COUNTY OF DEATH Montgomery	
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Gaithersburg	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 301 Russell Avenue		10f. ZIP CODE 20877	
10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) 4	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home		17. FATHER'S NAME (First, Middle, Last) William Knowles	
18. MOTHER'S NAME (First, Middle, Maiden Surname) Gertrude Miller		19a. INFORMANT'S NAME (Type/Print) Gary L. Gillard		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1811 Lawnview Drive, Frederick, Maryland 21701	
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Parview Cemetery April 27, 1995 Rockville, Maryland		20c. LOCATION — City or Town, State Rockville, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Richard C. Basford</i>		22. NAME AND ADDRESS OF FACILITY Keeney and Basford Funeral Home 106 East Church St., Frederick, Md. 21701		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Ischemic heart disease DUE TO (OR AS A CONSEQUENCE OF): b. Atherosclerotic Vascular disease DUE TO (OR AS A CONSEQUENCE OF): c. Diabetes mellitus DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Chronic renal failure Depression Spinal Stenosis Tobacco played no role in death	
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) April 22, 1995	
28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Byrl D. Johnson M.D.</i>		29c. LICENSE NUMBER D-19042		29d. DATE SIGNED (Month, Day, Year) April 23, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) BYRL D. JOHNSON 911 Russell Avenue Gaithersburg, Maryland 20879		31. DATE FILED (Month, Day, Year) APR 28 1995		32. REGISTRAR'S SIGNATURE <i>Johanna Davidson-Randall</i>	

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

95 13523

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>MARGARET Gable</u>				2. DATE OF DEATH MONTH <u>4</u> DAY <u>24</u> YEAR <u>95</u>		3. TIME OF DEATH <u>5</u> P.M.	
4. SOCIAL SECURITY NUMBER <u>219-30-6435</u>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <u>85</u> YRS.	IF UNDER 1 YEAR MONTHS _____ DAYS _____	IF UNDER 24 HRS. HOURS _____ MIN. _____	7. DATE OF BIRTH (Month, Day, Year) <u>6.15.09</u>	
9a. FACILITY NAME (If not institution, give street and number) <u>ST. MARY'S HOSPITAL</u>				9b. CITY, TOWN OR LOCATION OF DEATH <u>LEONARDTOWN MD</u>		9c. COUNTY OF DEATH <u>ST. MARY'S</u>	
RESIDENCE OF DECEDENT							
10a. STATE <u>MARYLAND</u>		10b. COUNTY <u>ST. MARY'S</u>		10c. CITY, TOWN OR LOCATION <u>AVENUE</u>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <u>LITTLE HECKLES FARM</u>				10f. ZIP CODE <u>20609</u>		10g. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>W</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Homemaker</u>		16b. KIND OF BUSINESS/INDUSTRY <u>Own Home</u>			
17. FATHER'S NAME (First, Middle, Last) <u>Charles Hedding</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Margaret unknown</u>			
19a. INFORMANT'S NAME (Type/Print) <u>Earl G. Gable</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>General Delivery, Avenue MD 20609</u>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Crestlawn Memorial Gardens 4-28</u>		DATE <u>4-28</u>		20c. LOCATION — City or Town, State <u>Marriottsville, MD</u>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Stanley M. Lewner</u>				22. NAME AND ADDRESS OF FACILITY <u>Harry H Witzke Funeral Home Inc 4112 Old Columbia Pike Ellicott City, 21043</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <u>PNEUMONIA</u> DUE TO (OR AS A CONSEQUENCE OF):					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST		b. <u>CARDIO PULMONARY ARREST.</u> DUE TO (OR AS A CONSEQUENCE OF):					
		c. _____ DUE TO (OR AS A CONSEQUENCE OF):					
		d. _____ DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>ORGANIC BRAIN SYNDROME</u>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <u>M</u>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <u>Thuma</u>				29c. LICENSE NUMBER <u>D34539</u>		29d. DATE SIGNED (Month, Day, Year) <u>4/24/95</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>KHAUD M. HUSAN MD, 662 MONROE ST #101 LEONARDTOWN MD 20650</u>							
31. DATE FILED (Month, Day, Year) <u>APR 27 1995</u>				32. REGISTRAR'S SIGNATURE <u>J. A. [Signature]</u>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

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95 13524

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Helen Elizabeth Giddings				2. DATE OF DEATH MONTH April DAY 19, YEAR 1995		3. TIME OF DEATH 4:45 p.m.	
4. SOCIAL SECURITY NUMBER 220 - 12 - 3797		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 79 YRS.	7. DATE OF BIRTH (Month, Day, Year) July 26, 1915		8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not institution, give street and number) Laurel Regional Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Laurel		9c. COUNTY OF DEATH Prince George	
10a. STATE Maryland				10b. COUNTY Howard		10c. CITY, TOWN OR LOCATION Laurel	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER 9841 Robinson Boulevard				10f. ZIP CODE 20723		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) Grade 10 College (1-4 or 5+) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Owner - Operator		16b. KIND OF BUSINESS/INDUSTRY Grocery Store			
17. FATHER'S NAME (First, Middle, Last) Spencer Giddings				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Dumhart			
19a. INFORMANT'S NAME (Type/Print) Mary Boyce				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9842 Robinson Blvd., Laurel, Maryland 20723			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Emmanuel Cemetery 4/22		20c. LOCATION — City or Town, State Scaggsville, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Louise Davidson</i>				22. NAME AND ADDRESS OF FACILITY Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Maryland 20707			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Septicemia DUE TO (OR AS A CONSEQUENCE OF): b. Aspiration Pneumonia DUE TO (OR AS A CONSEQUENCE OF): c. Arteriosclerotic Cerebrovascular Disease DUE TO (OR AS A CONSEQUENCE OF): d. Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death minutes days years
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide					
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>William A. Warren</i>				29c. LICENSE NUMBER D13916		29d. DATE SIGNED (Month, Day, Year) April 20, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) William A. Warren 321 Prince George Street, Laurel, Maryland 20707							
31. DATE FILED (Month, Day, Year) APR 27 1995				32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STANDARD

RECORD

COLLON

RECORD

95 13525

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) AKA RUTH J. GATES JERLINE RUTH GATES				2. DATE OF DEATH MONTH APRIL DAY 18 YEAR 1995		3. TIME OF DEATH 1417 M	
4. SOCIAL SECURITY NUMBER 214-36-0551		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 57 YRS.		7. DATE OF BIRTH (Month, Day, Year) October 6, 37	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) Frederick Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Frederick	
9c. COUNTY OF DEATH Frederick				10a. STATE Maryland			
10b. COUNTY Frederick				10c. CITY, TOWN OR LOCATION Frederick			
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 1000 Heather Ridge Drive			
10f. ZIP CODE 21701				10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Dietician		16b. KIND OF BUSINESS/INDUSTRY Food Service			
17. FATHER'S NAME (First, Middle, Last) Mitchell O. Gates				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Ruth Marlow			
19a. INFORMANT'S NAME (Type/Print) Walter C. Lynch				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 731, Waldorf, Maryland 20604			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of facility, cemetery or other place) Trinity Memorial Gdns. April 21, 1995		20c. LOCATION — City or Town, State Waldorf, Maryland		21. SIGNATURE OF FUNERAL SERVICE LICENSEE Mark G. Brohawn M00053	
22. NAME AND ADDRESS OF FACILITY THE HUNTT FUNERAL HOME, INC. P.O. BOX 156, WALDORF, MARYLAND 20604				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Intracranial Bleed DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death 3 days			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hx Deep Vein Thrombophlebitis & Multiple Pulmonary Emboli				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>				25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined			
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Philip Shapiro M.D.				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) 4/18/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Philip Shapiro 814 Tow House Ave, Frederick, MD 21701							
31. DATE FILED (Month, Day, Year) APR 20 1995				32. REGISTRAR'S SIGNATURE Julia Davidson Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Gladys Harrington</i>				2. DATE OF DEATH MONTH DAY YEAR <i>April 11 1995</i>				3. TIME OF DEATH <i>11:00 AM</i>	
4. SOCIAL SECURITY NUMBER <i>222-16-3195</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>73</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>7-4-1921</i>		8. BIRTHPLACE (State or Foreign Country) <i>DE.</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Salisbury Nursing & Rehab Center</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Salisbury, Md.</i>				9c. COUNTY OF DEATH <i>Wicomico</i>	
10a. STATE <i>Md.</i>				10b. COUNTY <i>Wicomico</i>		10c. CITY, TOWN OR LOCATION <i>Salisbury</i>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <i>Rt. 50 & Civic Ave.</i>				10f. ZIP CODE <i>21801</i>		10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <i>Elementary/Secondary (0-12)</i> <i>5</i>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Homemaker</i>		15b. KIND OF BUSINESS/INDUSTRY <i>Home</i>					
17. FATHER'S NAME (First, Middle, Last) <i>Clarence J. Harrington</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Annie Massey Harrington</i>					
19a. INFORMANT'S NAME (Type/Print) <i>Vernon W. Bailey, Sr.</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>27202 N Tourmaline Dr. Hebron, Md. 21830</i>					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Laurel Hill Cemetery</i>		DATE <i>4-14</i>		20c. LOCATION — City or Town, State <i>Laurel, De.</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>William M. Short</i>				22. NAME AND ADDRESS OF FACILITY <i>Short Funeral Home, Inc. 700 W. St. Laurel, De. 19956</i>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Myocardial infarction</i> DUE TO (OR AS A CONSEQUENCE OF): <i>hypertension</i> DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death <i>hrs</i> <i>min</i>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>William M. Short</i>				29c. LICENSE NUMBER <i>029549</i>		29d. DATE SIGNED (Month, Day, Year) <i>4/14/95</i>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>WILLIAM ROBINS, M.D., 1104 HEALTHWAY DR., Salisbury, Md.</i>									
31. DATE FILED (Month, Day, Year) <i>APR 14 1995</i>				32. REGISTRAR'S SIGNATURE <i>John Andrew Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13527

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Irving Holbrook				2. DATE OF DEATH MONTH 4 DAY 12 YEAR 95		3. TIME OF DEATH 2115 M	
4. SOCIAL SECURITY NUMBER 222-03-8120		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 77 YRS.		7. DATE OF BIRTH (Month, Day, Year) 7-06-17	
8. BIRTHPLACE (State or Foreign Country) Virginia				9a. FACILITY NAME (If not institution, give street and number) 608B South Westover Drive		9b. CITY, TOWN OR LOCATION OF DEATH Salisbury	
9c. COUNTY OF DEATH Wicomico							
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Wicomico		10c. CITY, TOWN OR LOCATION Salisbury		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 608 B S. Westover Drive				10f. ZIP CODE 21801		10g. CITIZEN OF WHAT COUNTRY? U.S.A	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (14 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Laborer		16b. KIND OF BUSINESS/INDUSTRY None			
17. FATHER'S NAME (First, Middle, Last) Charles Holbrook				18. MOTHER'S NAME (First, Middle, Maiden Surname) Sallie Hitch			
19a. INFORMANT'S NAME (Type/Print) Lucille Robinson				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 608 B. South Westover Dr. Salisbury, Md. 21801			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Springhill Gardens		DATE 4/17		20c. LOCATION — City or Town, State Hebron, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Gladys B. Stewart				22. NAME AND ADDRESS OF FACILITY Stewart Funeral Home 821 West Rd. Salisbury, Md. 21801			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Metastatic Carcinoma DUE TO (OR AS A CONSEQUENCE OF): Carcinoma Prostate DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Hyperthyroid, Hypertension Arteriosclerotic Cardiovascular Disease							Approximate Interval Between Onset and Death year years
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hyperthyroid, Hypertension Arteriosclerotic Cardiovascular Disease							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		28d. DESCRIBE NOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER John T. Bulkeley, M.D. DME				29c. LICENSE NUMBER D03599		29d. DATE SIGNED (Month, Day, Year) 4-13-95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John T. Bulkeley, M.D., 108 Pine Bluff Rd., Salisbury, Md. 21801							
31. DATE FILED (Month, Day, Year) APR 17 1995		32. REGISTRAR'S SIGNATURE John T. Bulkeley					

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

95 13528

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) HILL, CALVIN E.				2. DATE OF DEATH MONTH 4 DAY 13 YEAR 95		3. TIME OF DEATH 3:10 PM	
4. SOCIAL SECURITY NUMBER 226-36-5368		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 63 YRS.		7. DATE OF BIRTH (Month, Day, Year) 1-10-32	
8. BIRTHPLACE (State or Foreign Country) Virginia				9a. FACILITY NAME (If not institution, give street and number) McCready Hosp.		9b. CITY, TOWN OR LOCATION OF DEATH Crisfield Md	
9c. COUNTY OF DEATH Somerset				10a. STATE Md		10b. COUNTY Worcester	
10c. CITY, TOWN OR LOCATION Pocomoke City				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 1006 Market St	
10f. ZIP CODE 21851				10g. CITIZEN OF WHAT COUNTRY? USA.		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) College				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Tree Trimmer		16b. KIND OF BUSINESS/INDUSTRY Asplundak Co.	
17. FATHER'S NAME (First, Middle, Last) Winfred Hill				18. MOTHER'S NAME (First, Middle, Maiden Surname) Emma Justice			
19a. INFORMANT'S NAME (Type/Print) Mary E Walker				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6320 Circle Drive Chincoteague Va 23336			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) John Taylor Cem. 4/17/95		20c. LOCATION — City or Town, State Temperanceville Va	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Constance L. Bailey				22. NAME AND ADDRESS OF FACILITY Salver Funeral Home 6327 Church St. Chincoteague Va			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sepsis							
DUE TO (OR AS A CONSEQUENCE OF):							
a. Urinary Tract Infection							
DUE TO (OR AS A CONSEQUENCE OF):							
b. Neurogenic Bladder							
DUE TO (OR AS A CONSEQUENCE OF):							
c. Cervical Spine Injury							
DUE TO (OR AS A CONSEQUENCE OF):							
d. Cervical Spine Injury							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Pneumonia; Advanced Dementia Congestive Heart Failure Traumatic Paraplegia							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. PLACE OF INJURY — At home, farm, street, tectory, office building, etc. (Specify)				28d. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28e. DESCRIBE NOW INJURY OCCURRED	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER John S. Bellard MD		29c. LICENSE NUMBER D29505	
29d. DATE SIGNED (Month, Day, Year) 4-13-95				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) GREGORIO M. BELLOSO, M.D. 4421 BEECHWOOD PL. CRISFIELD, MD 21817			
31. DATE FILED (Month, Day, Year) APR 18 1995				32. REGISTRAR'S SIGNATURE John Davidson Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13529

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) SARA B. Hancock				2. DATE OF DEATH MONTH 4 DAY 16 YEAR 95		3. TIME OF DEATH 1050 M	
4. SOCIAL SECURITY NUMBER 230-56-7923		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 83 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 1, 1911	
9a. FACILITY NAME (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER				9b. CITY, TOWN OR LOCATION OF DEATH SALISBURY		9c. COUNTY OF DEATH WICOMICO	
RESIDENCE OF DECEDENT							
10a. STATE Virginia		10b. COUNTY Accomack		10c. CITY, TOWN OR LOCATION Chincoteague		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 6195 Ocean Blvd.				10f. ZIP CODE 23336		10g. CITIZEN OF WHAT COUNTRY? U. S. A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) 		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		15b. KIND OF BUSINESS/INDUSTRY Self			
17. FATHER'S NAME (First, Middle, Last) John Henry Marshall				18. MOTHER'S NAME (First, Middle, Maiden Surname) Julia Smith			
19a. INFORMANT'S NAME (Type/Print) Mary Clark				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6224 Ocean Blvd. Chincoteague, Virginia 23336			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of institution, cemetery, or other facility) Chincoteague Cemetery		DATE		20c. LOCATION — City or Town, State Chincoteague, Virginia	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Constance S.-G. Bailey				22. NAME AND ADDRESS OF FACILITY Salisbury Home Chincoteague, Virginia 23336			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
a. Cardiac arrest DUE TO (OR AS A CONSEQUENCE OF):							
b. Respiratory heart failure DUE TO (OR AS A CONSEQUENCE OF):							
c. Chronic heart disease DUE TO (OR AS A CONSEQUENCE OF):							
d.							
Approximate interval Between Onset and Death min hrs hrs							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes mellitus insulin requiring yrs Chronic renal failure yrs							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Clayton J. Raab M.D.				29c. LICENSE NUMBER D19289		29d. DATE SIGNED (Month, Day, Year) 4/16/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Clayton J. Raab M.D. P.O. Box 2636 Salisbury MD 21801							
31. DATE FILED (Month, Day, Year) APR 18 1995				32. REGISTRAR'S SIGNATURE John Davidson Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JAMES VIRGIL HANCOCK Sr.				2. DATE OF DEATH MONTH DAY YEAR APRIL 15 95				3. TIME OF DEATH 7:55A	
4. SOCIAL SECURITY NUMBER 214-36-5248		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 56 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7. DATE OF BIRTH (Month, Day, Year) April 22, 1938				8. BIRTHPLACE (State or Foreign Country) Maryland					
9a. FACILITY NAME (If not institution, give street and number) 60 FOOT ROAD AND US 50				9b. CITY, TOWN OR LOCATION OF DEATH PITTSVILLE				9c. COUNTY OF DEATH WICOMICO	
10a. STATE Maryland			10b. COUNTY Wicomico			10c. CITY, TOWN OR LOCATION Salisbury			10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
10e. STREET AND NUMBER 32986 Johnson Rd.				10f. ZIP CODE 21801				10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES Army		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Truck Driver/Poultry Grower				16b. KIND OF BUSINESS/INDUSTRY Trucking/Poultry	
17. FATHER'S NAME (First, Middle, Last) Ralph Hancock				18. MOTHER'S NAME (First, Middle, Maiden Surname) Flossie Perdue					
19a. INFORMANT'S NAME (Type/Print) Mary K. Hancock				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 32986 Johnson Rd., Salisbury, MD 21801					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Springhill Memory Gardens				DATE 4/18	20c. LOCATION — City or Town, State Hebron, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John N. Holburn</i>				22. NAME AND ADDRESS OF FACILITY Holloway Funeral Home 501 Snow Hill Rd., Salisbury, MD 21801					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → MULTIPLE TRAUMAS DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):								Approximate interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) ROAD							
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Nomicide		28a. DATE OF INJURY (Month, Day, Year) 4 15 95		28b. TIME OF INJURY 0720A M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED DRIVER OF PICKUP TRUCK STRUCK BY VEHICLE	
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) ROAD				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 60 FOOT RD AND US 50 WICOMICO MD			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Wayne Brubaker</i>				29c. LICENSE NUMBER O.C.M.E.				29d. DATE SIGNED (Month, Day, Year) APRIL 16/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARYANN A. KOREN MD 111 PENN STREET, BALTIMORE, MARYLAND 21201									
31. DATE FILED (Month, Day, Year) APR 18 1995				32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13531

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Marian Estelle Hense				2. DATE OF DEATH MONTH DAY YEAR April 17, 1995		3. TIME OF DEATH M 16:30	
4. SOCIAL SECURITY NUMBER 213 46 5613		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (in yrs. last birthday) 94 YRS.		7. DATE OF BIRTH (Month, Day, Year) Dec. 30, 1900	
8. BIRTHPLACE (State or Foreign Country) MD				9. FACILITY NAME (If not institution, give street and number) Calvert Memorial Hospital		10. CITY, TOWN OR LOCATION OF DEATH Prince Frederick	
11. COUNTY OF DEATH Calvert				12. STATE MD		13. COUNTY OF DEATH Calvert	
14. STREET AND NUMBER 5851 Mill Branch Rd.				15. ZIP CODE 20639		16. CITIZEN OF WHAT COUNTRY? USA	
17. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				18. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		19. RACE — American Indian, Black, White, etc. Specify: white	
20. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (13-16) 4				21. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) clerk		22. KIND OF BUSINESS/INDUSTRY U.S. Government	
23. FATHER'S NAME (First, Middle, Last) Arthur Fulton Middleton				24. MOTHER'S NAME (First, Middle, Maiden Surname) Susannah Estelle Brown			
25. INFORMANT'S NAME (Type/Print) Robert A. Hense				26. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) same as 10 above			
27. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				28. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) St John's Epis. Cem. 4-20-95		29. LOCATION — City or Town, State Beltsville, MD	
30. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				31. NAME AND ADDRESS OF FACILITY Rausch Funeral Home, PA Owings, MD 20736			
32. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pseudomonas skin infection DUE TO (OR AS A CONSEQUENCE OF): b. _____ c. _____ d. _____ SEQUENTIALLY LIST CONDITIONS, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST 1. _____ 2. _____ 3. _____ 4. _____							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Severe Dementia SIP P. E. G. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
33. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		34. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
35. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		36. DATE OF INJURY (Month, Day, Year)		37. TIME OF INJURY M		38. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
39. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		40. DESCRIBE HOW INJURY OCCURRED					
41. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		42. SIGNATURE AND TITLE OF CERTIFIER ATMund. M.D. Atending Phyc		43. LICENSE NUMBER D 19427		44. DATE SIGNED (Month, Day, Year) 4/18/95	
45. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Munshi Prince Frederick MD. 20678							
46. DATE FILED (Month, Day, Year) APR 21 1995		47. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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95 13532

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) FRANKLYN W. HOOK				2. DATE OF DEATH MONTH 4 - DAY 24 - YEAR 95		3. TIME OF DEATH 1336 M	
4. SOCIAL SECURITY NUMBER 228-42-4553		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 62 YRS.		7. DATE OF BIRTH (Month, Day, Year) 3/15/33	
8. BIRTHPLACE (State or Foreign Country) WASH DC				9a. FACILITY NAME (If not institution, give street and number) North Arundel Hosp		9b. CITY, TOWN OR LOCATION OF DEATH Glen Burnie	
9c. COUNTY OF DEATH AA				10a. STATE MD		10b. COUNTY A.A.	
10c. CITY, TOWN OR LOCATION Severna Park				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 2 Springhaven Court	
10f. ZIP CODE 21146				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES KOREAN				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: white				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+) 2			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) System Analyst				16b. KIND OF BUSINESS/INDUSTRY NSA			
17. FATHER'S NAME (First, Middle, Last) Charles Wallace Hook				18. MOTHER'S NAME (First, Middle, Maiden Surname) Clarissa Waple			
19a. INFORMANT'S NAME (Type/Print) PATRICIA HOOK				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) SAME AS #10			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory 4-28-95 Catonsville, MD			
20c. LOCATION — City or Town, State				21. SIGNATURE OF FUNERAL SERVICE LICENSEE Robert S. B...			
22. NAME AND ADDRESS OF FACILITY BARRANCO AND SONS FUNERAL HOME 495 Ritchie Hwy Severna Park MD				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Ventricular Fibrillation DUE TO (OR AS A CONSEQUENCE OF): AS CVD Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. AS CVD DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO				DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year) 4/24/95			
28b. TIME OF INJURY M				28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER William P. Jones, MD Deputy				29c. LICENSE NUMBER D 06054			
29d. DATE SIGNED (Month, Day, Year) 4/24/95				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) William P. Jones, MD, 695 America 21035			
31. DATE FILED (Month, Day, Year) APR 27 1995				32. REGISTRAR'S SIGNATURE John Andrew Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13533

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JAMES E. HICKS				2. DATE OF DEATH MONTH DAY YEAR APRIL 17 1995		3. TIME OF DEATH 8:15am M											
4. SOCIAL SECURITY NUMBER 220-58-1403		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 49 YRS.		7. DATE OF BIRTH (Month, Day, Year) MAY 28 1945											
8. BIRTHPLACE (State or Foreign Country) D.C.				9a. FACILITY NAME (If not institution, give street and number) 1121 EASTPORT TERRACE		9b. CITY, TOWN OR LOCATION OF DEATH ANNAPOLIS											
9c. COUNTY OF DEATH ANNE ARUNDEL				10a. STATE MARYLAND		10b. COUNTY ANNE ARUNDEL											
10c. CITY, TOWN OR LOCATION ANNAPOLIS				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 1121 EASTPORT TERRACE											
10f. ZIP CODE 21403				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced											
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK											
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4th College (1-4 or 5+) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) DISABLED		16b. KIND OF BUSINESS/INDUSTRY											
17. FATHER'S NAME (First, Middle, Last) JOSEPH HICKS				18. MOTHER'S NAME (First, Middle, Maiden Surname) ANNIE SIMMS													
19a. INFORMANT'S NAME (Type/Print) ANNIE SIMMS				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1121 EASTPORT TERRACE ANNAPOLIS, MD. 21403													
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium or other place) ANNAPOLIS MEM. GARDENS 4/24/95		20c. LOCATION — City or Town, State ANNAPOLIS, MD.											
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Larry H. Reese</i>				22. NAME AND ADDRESS OF FACILITY REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401													
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																	
IMMEDIATE CAUSE (Final disease or condition resulting in death) →																	
<table border="0"> <tr> <td>a. <i>Cardio pulmonary arrest</i></td> <td>Approximate Interval Between Onset and Death</td> </tr> <tr> <td>b. <i>Cerebral palsy</i></td> <td><i>4-17-95</i></td> </tr> <tr> <td>c. <i>Chronic renal failure</i></td> <td><i>5/28/45</i></td> </tr> <tr> <td>d. <i>Epilepsy disorder</i></td> <td><i>7/25/84</i></td> </tr> <tr> <td></td> <td><i>5/28/45</i></td> </tr> </table>								a. <i>Cardio pulmonary arrest</i>	Approximate Interval Between Onset and Death	b. <i>Cerebral palsy</i>	<i>4-17-95</i>	c. <i>Chronic renal failure</i>	<i>5/28/45</i>	d. <i>Epilepsy disorder</i>	<i>7/25/84</i>		<i>5/28/45</i>
a. <i>Cardio pulmonary arrest</i>	Approximate Interval Between Onset and Death																
b. <i>Cerebral palsy</i>	<i>4-17-95</i>																
c. <i>Chronic renal failure</i>	<i>5/28/45</i>																
d. <i>Epilepsy disorder</i>	<i>7/25/84</i>																
	<i>5/28/45</i>																
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.																	
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO																	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO																	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>																	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) <i>At home</i>													
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO											
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED													
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)													
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																	
29b. SIGNATURE AND TITLE OF CERTIFIER <i>M. M. Mullins, MD</i>				29c. LICENSE NUMBER D26375		29d. DATE SIGNED (Month, Day, Year) 4/25/95											
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type, Print) 586 Bellevue Dr. Annapolis, Md 21401																	
31. DATE FILED (Month, Day, Year) 4-1 APR 27 1995				32. REGISTRAR'S SIGNATURE <i>John A. ...</i>													

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL DR. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13534

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Elizabeth Jones Hearne				2. DATE OF DEATH MONTH April DAY 20 YEAR 1995		3. TIME OF DEATH 2:25 P M	
4. SOCIAL SECURITY NUMBER 213-48-5561		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 88 YRS.		7. DATE OF BIRTH (Month, Day, Year) 7/29/1906	
9a. FACILITY NAME (If not institution, give street and number) Berlin Nursing & Rehab.Center				9b. CITY, TOWN OR LOCATION OF DEATH Berlin		9c. COUNTY OF DEATH Worcester	
10a. STATE Md.				10b. COUNTY Worcester		10c. CITY, TOWN OR LOCATION Snow Hill	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
10e. STREET AND NUMBER 111 Franklin Street				10f. ZIP CODE 21863		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) 		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY own home			
17. FATHER'S NAME (First, Middle, Last) William T. Hearne				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Jones Hearne			
19a. INFORMANT'S NAME (Type/Print) Ann Wilcox				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 111 Franklin St., Snow Hill, Md. 21863			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Whatcoat Meth. Cemet. 4/22		20c. LOCATION — City or Town, State Snow Hill, Md. 21863			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Patricia L. Dennis</i>				22. NAME AND ADDRESS OF FACILITY Dennis Funeral Home, Snow Hill, Md.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <i>Pseudomembranous Colitis, Severe</i>					Approximate Interval Between Onset and Death 1 month
		b. <i>Clostridium difficile Colitis</i>					1 month
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST		c. 					
		d. 					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Right Lower Lobe Pneumonitis</i> <i>Seizure Disorder</i>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Gregorio B. Belloso M.D.</i>				29c. LICENSE NUMBER D29505		29d. DATE SIGNED (Month, Day, Year) 4-20-95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Gregorio Belloso, MD 4421 Beechwood Place Crisfield MD 21817							
31. DATE FILED (Month, Day, Year) APR 21 1995		32. REGISTRAR'S SIGNATURE <i>John B. Belloso</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13535

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) CHARLES BRYAN HUFFER				2. DATE OF DEATH MONTH DAY YEAR APRIL 8, 1995		3. TIME OF DEATH 0500	
4. SOCIAL SECURITY NUMBER 218-24-2281		5. SEX 1 <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 62 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 20, 1932	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) Washington Adventist Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Takoma Park	
9c. COUNTY OF DEATH Montgomery				10a. STATE Maryland		10b. COUNTY Prince George's	
10c. CITY, TOWN OR LOCATION Seabrook				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 6803 94th Avenue	
10f. ZIP CODE 20706				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 2 <input checked="" type="checkbox"/> Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Frame Man		16b. KIND OF BUSINESS/INDUSTRY C & P Telephone			
17. FATHER'S NAME (First, Middle, Last) Jacob B. Huffer				18. MOTHER'S NAME (First, Middle, Maiden Surname) Elsie L. Boteler			
19a. INFORMANT'S NAME (Type/Print) Joan P. Huffer				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6803 94th Avenue, Seabrook, Maryland 20706			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Fort Lincoln Cemetery 04/10/95		20c. LOCATION — City or Town, State Brentwood, Maryland		20d. DATE 04/10/95	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE W.B. Grier				22. NAME AND ADDRESS OF FACILITY Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → carcinoma of colon DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. prolonged systolic hypertension chronic obstructive pulmonary disease DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER DR. LEWIS DENNIS				29c. LICENSE NUMBER PO1499		29d. DATE SIGNED (Month, Day, Year) Apr. 8, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. LEWIS DENNIS				31. DATE FILED (Month, Day, Year) APR 10 1995			
32. REGISTRAR'S SIGNATURE John A. Huffer							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13536

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Brian Kennard Henderson				2. DATE OF DEATH MONTH DAY YEAR April 6, 1995		3. TIME OF DEATH 13:00 M	
4. SOCIAL SECURITY NUMBER 579-90-5538		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 19 YRS.		7. DATE OF BIRTH (Month, Day, Year) May 21, 1975	
9a. FACILITY NAME (If not institution, give street and number) 2823 Hilton Drive				9b. CITY, TOWN OR LOCATION OF DEATH Lexington Park		9c. COUNTY OF DEATH St. Mary's	
10a. STATE Maryland				10b. COUNTY St. Mary's		10c. CITY, TOWN OR LOCATION Lexington Park	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER 2823 Hilton Drive				10f. ZIP CODE 20653		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Delivery		16b. KIND OF BUSINESS/INDUSTRY Delivery			
17. FATHER'S NAME (First, Middle, Last) William Henderson				18. MOTHER'S NAME (First, Middle, Maiden Surname) Brenda Haeb's Henderson			
19a. INFORMANT'S NAME (Type/Print) Brenda Henderson				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2823 Hilton Dr. Lexington Park, Md. 20653			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) N. Virginia Crematory 4-6-95		20c. LOCATION — City or Town, State Arlington, Va.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Stonewall J. Howard Jr.				22. NAME AND ADDRESS OF FACILITY Capitol Mortuary 1425 Maryland Ave., N.E. Wash. D.C.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Gunshot wound to the head DUE TO (OR AS A CONSEQUENCE OF): b. Suicide DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Depression							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 4-6-95		28b. TIME OF INJURY 1300 M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED GSCW-Suicide		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) Home		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 2823 Hilton Dr.			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER William D. Boyd II, M.D.				29c. LICENSE NUMBER D14285		29d. DATE SIGNED (Month, Day, Year) 7 April 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) William D. Boyd II, M.D., 17 Jefferson Street, Leonardtown, Maryland 20650							
31. DATE FILED (Month, Day, Year) APR 12 1995				32. REGISTRAR'S SIGNATURE Juba Davidson-Hendall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 28 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13537

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Lenice Elva Lane Harding				2. DATE OF DEATH MONTH DAY YEAR April 5, 1995		3. TIME OF DEATH 7:30 P. M.	
4. SOCIAL SECURITY NUMBER 577-18-9835		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 83 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 15, 1911	
8. BIRTHPLACE (State or Foreign Country) North Carolina				9a. FACILITY NAME (If not institution, give street and number) Washington Adventist Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Takoma Park	
9c. COUNTY OF DEATH Montgomery				10a. STATE Maryland		10b. COUNTY Prince George's	
10c. CITY, TOWN OR LOCATION Mt. Rainier				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 2903 Bunker Hill Road	
10f. ZIP CODE 20712				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Operator		16b. KIND OF BUSINESS/INDUSTRY C & P Telephone Company	
17. FATHER'S NAME (First, Middle, Last) William Thomas Lane				18. MOTHER'S NAME (First, Middle, Maiden Surname) Charlotte Lottie Gentle			
19a. INFORMANT'S NAME (Type/Print) Lynwood Julian Harding				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24153 Lemay Street, West Hills, California 91307			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Fort Lincoln Cemetery 04/08/95		20c. LOCATION — City or Town, State Brentwood, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>W.B. Gessner</i>				22. NAME AND ADDRESS OF FACILITY Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cerebral vascular accident DUE TO (OR AS A CONSEQUENCE OF): Cerebral bleed Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUMBER D22639		29d. DATE SIGNED (Month, Day, Year) APRIL 5, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Fayaz A. Shawl, M.D. 3001 Hospital Drive #H403, Cheverly, Maryland 20785							
31. DATE FILED (Month, Day, Year) APR 10 1995				32. REGISTRAR'S SIGNATURE <i>Julia Davidson Radtke</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13538

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ZEMORIA I. HARRIS				2. DATE OF DEATH MONTH DAY YEAR APRIL 3 1995		3. TIME OF DEATH 10:00 A M	
4. SOCIAL SECURITY NUMBER 578-22-1250		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (in yrs. last birthday) 71 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 1/25/24	
9a. FACILITY NAME (If not institution, give street and number) Prince George's Hosp. Center				9b. CITY, TOWN OR LOCATION OF DEATH Cheverly		9c. COUNTY OF DEATH Prince George's	
RESIDENCE OF DECEDENT							
10a. STATE Md.		10b. COUNTY P.G.		10c. CITY, TOWN OR LOCATION Bladensburg		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 5802 Annapolis Rd. # 808				10f. ZIP CODE		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) 12th		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) File Clerk		16b. KIND OF BUSINESS/INDUSTRY U.S. Government			
17. FATHER'S NAME (First, Middle, Last) William I. Harris				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ida V. Bell			
19a. INFORMANT'S NAME (Type/Print) Ida V. Harris				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as # 10 above			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Mt. Olivet Cem. 4/7/95		DATE		20c. LOCATION — City or Town, State Wash., D.C.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Larry N. Pratt				22. NAME AND ADDRESS OF FACILITY H.S. Washington & Sons, Inc. 4925 Burroughs Ave., N.E.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. RESPIRATORY FAILURE DUE TO (OR AS A CONSEQUENCE OF): b. S/P - Adult Resp. distress syndrome. DUE TO (OR AS A CONSEQUENCE OF): c. H/O - Carcinoma, vulva. DUE TO (OR AS A CONSEQUENCE OF): d. H/O - Lupus. Approximate interval Between Onset and Death > 30 days > 30 days							
Sequitely ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HTN / S/P - cystectomy / Trache / G-lube patient was - DNR.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO N/A					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide 4 <input type="checkbox"/>		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER S. J. Rao, MD				29c. LICENSE NUMBER D-34525		29d. DATE SIGNED (Month, Day, Year) APR - 4th - 95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) S. J. Rao, MD - 4000-Mitchellville Road, # 220 ; Bowie - MD - 20716.							
31. DATE FILED (Month, Day, Year) APR 10 1995		32. REGISTRAR'S SIGNATURE John Davidson					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) RONNIE HEBRON				2. DATE OF DEATH MONTH DAY YEAR MARCH 29 1995				3. TIME OF DEATH 9:45 P M							
4. SOCIAL SECURITY NUMBER %& 578-72-1677		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 39 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) July 20, 1955		8. BIRTHPLACE (State or Foreign Country) Washington, DC			
9a. FACILITY NAME (If not institution, give street and number) PRINCE GEORGES HOSPITAL CENTER						9b. CITY, TOWN OR LOCATION OF DEATH CHEVERLY				9c. COUNTY OF DEATH PRINCE GEORGES					
RESIDENCE OF DECEDENT															
10a. STATE		10b. COUNTY		10c. CITY, TOWN OR LOCATION Washington, D.C.						10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO					
10e. STREET AND NUMBER 1063 44th. Street, N.E. #B				10f. ZIP CODE 20019				10g. CITIZEN OF WHAT COUNTRY? U.S.A.							
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: Black					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 11				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Disabled				16b. KIND OF BUSINESS/INDUSTRY							
17. FATHER'S NAME (First, Middle, Last) Robert D. Hebron						18. MOTHER'S NAME (First, Middle, Maiden Surname) Louise Holiday									
19a. INFORMANT'S NAME (Type/Print) Carloyn Hebron						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1063 44th. St., N.E., Washington, D.C., 20019									
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Harmony Memorial Pk. 4/4/95				DATE		20c. LOCATION — City or Town, State Landover, Md.					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE W. J. Jeffers						22. NAME AND ADDRESS OF FACILITY Frazier Funeral Home 389 Rhode Island Av., NW, Washington, D.C.									
23. PART I. Enter the disease or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.												Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HEALED ENDOCARDITIS, MITRAL VALVE WITH REGURGITATION												24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>															
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> XER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
29b. SIGNATURE AND TITLE OF CERTIFIER John R. Locke, MD						29c. LICENSE NUMBER O.C.M.E		29d. DATE SIGNED (Month, Day, Year) MARCH 30, 1995							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John R. Locke, MD 11 PENN STREET, BALTIMORE, MARYLAND 21201															
31. DATE FILED (Month, Day, Year) APR 11 1995				32. REGISTRAR'S SIGNATURE John R. Locke											

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

95 13540

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) HORALD HOLMAN				2. DATE OF DEATH MONTH 3 DAY 29 YEAR 95 TIME OF DEATH 5:20 PM			
4. SOCIAL SECURITY NUMBER 135-36-6728		5. SEX 1 <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 51 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) July 30, 1943	
8. BIRTHPLACE (State or Foreign Country) Farmville, Va.							
9a. FACILITY NAME (If not institution, give street and number) Mercy Medical Center				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT							
10a. STATE Virginia		10b. COUNTY		10c. CITY, TOWN OR LOCATION Richmond		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 2903 E. Marshall Street				10f. ZIP CODE 23223		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) 12 Elementary/Secondary (0-12) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Mechanic		16b. KIND OF BUSINESS/INDUSTRY Private			
17. FATHER'S NAME (First, Middle, Last) Maynard Ross Holman				18. MOTHER'S NAME (First, Middle, Maiden Surname) Helen Holman			
19a. INFORMANT'S NAME (Type/Print) Louise Holman				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2903 E. Marshall St. Richmond, Va. 23223			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Oakwood Cemetery		DATE 3/2		20c. LOCATION — City or Town, State Richmond, Va.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Plunkett Funeral Home, Wash., D. C.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. infarction of bowel DUE TO (OR AS A CONSEQUENCE OF) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death 45 hours
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D 243-55 MD		29d. DATE SIGNED (Month, Day, Year) 3/29/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Dingle							
31. DATE FILED (Month, Day, Year) APR 11 1995 							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95-2307-001
DWG

Amended #1 4/21/95 LAC, Allegany Co

95 13541

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) EDWIN DONALD HARTMAN, SR.				2. DATE OF DEATH MONTH DAY YEAR APRIL 19 95		3. TIME OF DEATH 11:15 P M	
4. SOCIAL SECURITY NUMBER 212-24-2207		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 66 YRS.		7. DATE OF BIRTH (Month, Day, Year) Jan. 17, 1929	
9a. FACILITY NAME (If not institution, give street and number) 11316 VALLEY ROAD, N.E.				9b. CITY, TOWN OR LOCATION OF DEATH CUMBERLAND		9c. COUNTY OF DEATH ALLEGANY	
10a. STATE MARYLAND				10b. COUNTY ALLEGANY		10c. CITY, TOWN OR LOCATION CUMBERLAND	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 11316 VALLEY ROAD, N.E.		10f. ZIP CODE 21502	
10g. CITIZEN OF WHAT COUNTRY? U.S.A.				11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES KOREAN CONFLICT	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: WHITE			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) 12				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) OWNER/OPERATOR		16b. KIND OF BUSINESS/INDUSTRY GROCERY STORE	
17. FATHER'S NAME (First, Middle, Last) EDWIN BONNIE HARTMAN				18. MOTHER'S NAME (First, Middle, Maiden Surname) MARGARET VIOLA TROST			
19a. INFORMANT'S NAME (Type/Print) LINDA M. HARTMAN				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11316 VALLEY RD., N.E.-CUMBERLAND, MD 21502			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) SUNSET MEMORIAL PARK 4/22/95		20c. LOCATION — City or Town, State CUMBERLAND, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>George Upchurch</i>				22. NAME AND ADDRESS OF FACILITY GEORGE-UPCHURCH FUNERAL HOME, P.A. 202 GREENE ST., CUMBERLAND, MD 21502			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Multiple Stab and Cutting Wounds DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? XX YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) STORE		24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year) 4/19/95		28b. TIME OF INJURY 2205 M	
28c. INJURY AT WORK? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED Subcut stabbed		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) 11316 Valley Road	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <i>Carla Locke MD</i> 29b. SIGNATURE AND TITLE OF CERTIFIER CARLA LOCKE MD 29c. LICENSE NUMBER O.C.M.E. 29d. DATE SIGNED (Month, Day, Year) APRIL 20/95							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J. LARON LOCKE MD 111 PENN STREET, BALTIMORE MARYLAND 21201							
31. DATE FILED (Month, Day, Year) APR 21 1995				32. REGISTRAR'S SIGNATURE <i>Carla Locke</i>			

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Amended #5 10C, 19a; 4/19/95, M.D.S., Allegany Co.

95 13542

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Mary Elizabeth Hancock				2. DATE OF DEATH MONTH DAY YEAR April 13, 1995				3. TIME OF DEATH 18:30 P.M.			
4. SOCIAL SECURITY NUMBER 219-14-5040		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 73 YRS.	7. DATE OF BIRTH (Month, Day, Year) Apr. 11, 1922		8. BIRTHPLACE (State or Foreign Country) Pennsylvania					
9a. FACILITY NAME (If not institution, give street and number) CALVERT MEMORIAL HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH PRINCE FREDERICK				9c. COUNTY OF DEATH CALVERT			
10a. STATE Maryland		10b. COUNTY Prince George's		10c. CITY, TOWN OR LOCATION Capital Heights				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER 4802 Fable Street				10f. ZIP CODE 20743		10g. CITIZEN OF WHAT COUNTRY? U.S.A.					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 1		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Acct. Rec. Supervisor		16b. KIND OF BUSINESS/INDUSTRY Air products and chemicals							
17. FATHER'S NAME (First, Middle, Last) William E. Lauterbach				18. MOTHER'S NAME (First, Middle, Maiden Surname) Cecelia Catherine Bergman							
19a. INFORMANT'S NAME (Type/Print) Dorothea Lauterbach				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14922 Winchester Rd-Cresaptown, MD 21502							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) SS. Peter & Paul Cem. 4/18/95		DATE 4/18/95		20c. LOCATION — City or Town, State Cumberland, MD					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Theresa P. Upchurch				22. NAME AND ADDRESS OF FACILITY George-Upchurch Funeral Home, P.A. 202 Greene St., Cumberland, MD 21502							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. MYOCARDIAL INFARCTION DUE TO (OR AS A CONSEQUENCE OF): b. CHRONIC ATRIAL FIBRILLATION DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death 1 WK. 5 YRS.			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER Dr. Charles Judge						29c. LICENSE NUMBER D29657		29d. DATE SIGNED (Month, Day, Year) 4/14/95			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Charles Judge Prince Frederick, MD 20678											
31. DATE FILED (Month, Day, Year) APR 19 1995				32. REGISTRAR'S SIGNATURE John A. ...							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Amended 10e, 4/19/95, N.D.S., Allegany Co.

95 13543

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) FRANCIS B. HARVEY				2. DATE OF DEATH MONTH APRIL DAY 17 YEAR 1995				3. TIME OF DEATH 04:50 A.M.	
4. SOCIAL SECURITY NUMBER 214-07-3186		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 79 YRS.		7. DATE OF BIRTH (Month, Day, Year) Sept. 28, 1915		8. BIRTHPLACE (State or Foreign Country) Maryland		
9a. FACILITY NAME (If not institution, give street and number) SACRED HEART HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH CUMBERLAND				9c. COUNTY OF DEATH ALLEGANY	
10a. STATE MARYLAND		10b. COUNTY ALLEGANY		10c. CITY, TOWN OR LOCATION CUMBERLAND				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 12708 N. CRESAP STREET				10f. ZIP CODE 21502		10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES W.W.II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) 		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SPINNER		16b. KIND OF BUSINESS/INDUSTRY CELANESE FIBERS CORPORATION					
17. FATHER'S NAME (First, Middle, Last) MICHAEL SHAY HARVEY				18. MOTHER'S NAME (First, Middle, Maiden Surname) CARRIE HANORA SHUCK					
19a. INFORMANT'S NAME (Type/Print) WILLIAM F. HARVEY				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1216 MENDELSSOHN CT., VIRGINIA BEACH, VA 23454					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) SUNSET MEMORIAL PARK 4/20/95				20c. LOCATION — City or Town, State CUMBERLAND, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Wendy G. Lockman</i>				22. NAME AND ADDRESS OF FACILITY GEORGE-UPCHURCH FUNERAL HOME, P.A. 202 GREENE ST., CUMBERLAND, MD 21502					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Coronary Heart failure with respiratory failure DUE TO (OR AS A CONSEQUENCE OF): Brain stem stroke. DUE TO (OR AS A CONSEQUENCE OF): Arteriosclerotic cardiovascular disease DUE TO (OR AS A CONSEQUENCE OF): Hypertension / Hypothyroidism Approximate interval between Onset and Death 5 days 7 days 10 yrs. 10 yrs. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Chronic obstructive pulmonary disease Coronary artery disease PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>V. RAUL FELIPA</i> M.D. FACP				29c. LICENSE NUMBER D13601		29d. DATE SIGNED (Month, Day, Year) APRIL 17th 1995			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) V. RAUL FELIPA 925 Bishop Walsh Rd Cumberland									
31. DATE FILED (Month, Day, Year) APR 19 1995				32. REGISTRAR'S SIGNATURE <i>Jula</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10/11/01
10/11/01

95 13544

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JOHN VERNON HUMBERTSON				2. DATE OF DEATH MONTH DAY YEAR Apr. 17, 1995		3. TIME OF DEATH 3:55 PM	
4. SOCIAL SECURITY NUMBER 217-30-1889		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 73 YRS.		7. DATE OF BIRTH (Month, Day, Year) Sep 27, 1921	
9a. FACILITY NAME (If not institution, give street and number) 516 WARREN STREET		9b. CITY, TOWN OR LOCATION OF DEATH CUMBERLAND		9c. COUNTY OF DEATH ALLEGANY			
RESIDENCE OF DECEDENT							
10a. STATE MD		10b. COUNTY Allegany		10c. CITY, TOWN OR LOCATION Cumberland		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 516 Warren Street				10f. ZIP CODE 21502		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) _____		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Truck Driver		16b. KIND OF BUSINESS/INDUSTRY Trucking			
17. FATHER'S NAME (First, Middle, Last) Frank Humbertson				18. MOTHER'S NAME (First, Middle, Maiden Surname) Myrtle King			
19a. INFORMANT'S NAME (Type/Print) Connie Twigg				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 E. Clement Street; Cumberland, MD 21502			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) _____		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Pleasant Grove Cemetery 04/20		20c. LOCATION — City or Town, State Cumberland, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE James J. Scarpelli				22. NAME AND ADDRESS OF FACILITY Scarpelli Funeral Home Cumberland, MD 21502			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Myocardial infarction DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. Arteriosclerosis DUE TO (OR AS A CONSEQUENCE OF): c. Coronary atherosclerosis DUE TO (OR AS A CONSEQUENCE OF): d. Ischemic heart disease							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Home					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER John B. ... MD				29c. LICENSE NUMBER D12532		29d. DATE SIGNED (Month, Day, Year) April 18, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 912 ... Cumberland, Md 21502							
31. DATE FILED (Month, Day, Year) APR 19 1995		32. REGISTRAR'S SIGNATURE John ...					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13545

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Chloe Viola HARRIS				2. DATE OF DEATH MONTH DAY YEAR April 20, 1995		3. TIME OF DEATH 3:15 P. M.	
4. SOCIAL SECURITY NUMBER 212-24-7414		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 90 YRS.		7. DATE OF BIRTH (Month, Day, Year) April 11, 1905	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) Meridian Nursing Home		9b. CITY, TOWN OR LOCATION OF DEATH Frederick	
9c. COUNTY OF DEATH Frederick				10a. STATE Maryland		10b. COUNTY Frederick	
10c. CITY, TOWN OR LOCATION Frederick				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 8951-A Indian Springs Road	
10f. ZIP CODE 21702				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+) 7				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Cook		16b. KIND OF BUSINESS/INDUSTRY Nursing Home	
17. FATHER'S NAME (First, Middle, Last) Charles Linton				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ada Gilbert			
19a. INFORMANT'S NAME (Type/Print) Betty H. Engle				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8951-B Indian Springs Rd., Frederick, Md. 21702			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Pleasant Hill Cemetery April 24, 1995 Frederick, Md.		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Supere C.C. Basford M00021				22. NAME AND ADDRESS OF FACILITY Keeney and Basford Funeral Home 106 East Church St., Frederick, Md. 21701			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
a. pneumonia DUE TO (OR AS A CONSEQUENCE OF):							
b. Stroke DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Atherosclerotic Heart Disease							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER C. E. Cline				29c. LICENSE NUMBER D16428		29d. DATE SIGNED (Month, Day, Year) 4/21/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Casper E. Cline, III, 300 West Ninth Street, Frederick, Maryland 21701							
31. DATE FILED (Month, Day, Year) APR 24 1995				32. REGISTRAR'S SIGNATURE J. H. Anderson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13546

FOR
STATE
REGISTRAR **RICHARD RODNEY HANSELL** **CERTIFICATE OF DEATH** REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Richard Rodney Hansell						2. DATE OF DEATH MONTH APRIL DAY 21 YEAR 1995		3. TIME OF DEATH 0940 A.M.	
4. SOCIAL SECURITY NUMBER 163-24-1858		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 63 YRS.		7. DATE OF BIRTH (Month, Day, Year) Oct. 15, 1931		8. BIRTHPLACE (State or Foreign Country) Pennsylvania	
9a. FACILITY NAME (If not institution, give street and number) 335 West Main Street						9b. CITY, TOWN OR LOCATION OF DEATH Thurmont		9c. COUNTY OF DEATH Frederick	
RESIDENCE OF DECEDENT									
10a. STATE Virginia		10b. COUNTY Fairfax		10c. CITY, TOWN OR LOCATION Vienna				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 1852 Abbotsford Drive				10f. ZIP CODE 22182-3301		10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 1 College (1-4 or 5+) 1			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Visual Information Specialist			16b. KIND OF BUSINESS/INDUSTRY U.S. Geological Survey			
17. FATHER'S NAME (First, Middle, Last) Howard H. HANSELL						18. MOTHER'S NAME (First, Middle, Maiden Surname) Jane SIMMS			
19a. INFORMANT'S NAME (Type/Print) Lawrence J. Long				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1852 Abbotsford Drive, Vienna, Va. 22182-3301					
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Smithsburg Crematory, Apr. 24, 1995 Smithsburg, Maryland				20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Allan H. Ruby M00703				22. NAME AND ADDRESS OF FACILITY Keeney & Basford P.A. Funeral Home 106 East Church St., Frederick, MD 21701					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death Minutes	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER Robert R. Roberts MD						29c. LICENSE NUMBER D09867		29d. DATE SIGNED (Month, Day, Year) APRIL 21 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 15 W 7TH ST FREDERICK MD 21701-4599									
31. DATE FILED (Month, Day, Year) APR 24 1995		32. REGISTRAR'S SIGNATURE Julia Anderson-Rodella							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13547

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Oscar P. Harry				2. DATE OF DEATH MONTH 4 DAY 27 YEAR 1995		3. TIME OF DEATH 0615 AM	
4. SOCIAL SECURITY NUMBER 219 10 2488		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 69 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0	IF UNDER 24 HRS. HOURS 0 MIN. 0	7. DATE OF BIRTH (Month, Day, Year) May 18, 1925	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) Kimbrough Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Fort Meade	
9c. COUNTY OF DEATH Anne Arundel				10a. STATE Maryland		10b. COUNTY Anne Arundel	
10c. CITY, TOWN OR LOCATION Harmans				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 18 Hanford Drive	
10f. ZIP CODE 21077				10g. CITIZEN OF WHAT COUNTRY? United States		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1943 - 1965				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Salesman		16b. KIND OF BUSINESS/INDUSTRY Insurance Company	
17. FATHER'S NAME (First, Middle, Last) Oscar P. Harry Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Emma Weber			
19a. INFORMANT'S NAME (Type/Print) Mrs. Elisa L. Harry				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18 Hanford Drive Harmans, Maryland 21077			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Meadowridge Cemetery May 1		20c. LOCATION — City or Town, State Elkridge, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Stanley M. Loewner				22. NAME AND ADDRESS OF FACILITY Harry H Witzke Funeral Home Inc 4112 Old Columbia Pike Ellicott City 21043			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Atherosclerotic Coronary Artery Disease Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. Hypertension c. Chronic Obstructive Pulmonary Disease - Severe							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Robert Wolfgang, Robert CPT MC				29c. LICENSE NUMBER H 43958		29d. DATE SIGNED (Month, Day, Year) 4/27/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ROBERT WOLFGANG, CPT, MC KIMBROUGH ARMY HOSPITAL, FT. MEADE, MD 20755							
31. DATE FILED (Month, Day, Year) APR 28 1995				32. REGISTRAR'S SIGNATURE John Davidson Randall			

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

95 13548

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) Arshad Imam				2. DATE OF DEATH MONTH DAY YEAR April 21, 1995				3. TIME OF DEATH 3:00 P M					
4. SOCIAL SECURITY NUMBER None		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 55 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) Sep 30, 1939		8. BIRTHPLACE (State or Foreign Country) India	
9a. FACILITY NAME (If not institution, give street and number) Frederick Memorial Hospital						9b. CITY, TOWN OR LOCATION OF DEATH Frederick				9c. COUNTY OF DEATH Frederick			
RESIDENCE OF DECEASED													
10a. STATE Pakistan		10b. COUNTY		10c. CITY, TOWN OR LOCATION Karachi				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
10e. STREET AND NUMBER R-288 Metroville III, Gulshan-e-igbal						10f. ZIP CODE None		10g. CITIZEN OF WHAT COUNTRY? Pakistan					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: Pakistani			
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (8-12) College (1-4 or 5+) 4				15a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Banking Officer				15b. KIND OF BUSINESS/INDUSTRY Habib Bank, Ltd					
17. FATHER'S NAME (First, Middle, Last) Mohammed IMAM						18. MOTHER'S NAME (First, Middle, Maiden Surname) Mujib - Un - Nessa							
19a. INFORMANT'S NAME (Type/Print) Azra Imam						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) R-288 Metroville III, Blck 1, Karachi, Pakistan							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Oaklawn Mem Park Apr 23, 1995				OATE		20c. LOCATION — City or Town, State Princeton, New Jersey			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Kathryn Robertson</i> 00706						22. NAME AND ADDRESS OF FACILITY Keeney & Basford P.A. Funeral Home 106 East Church St. Frederick, MD 21701							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>cardiac ischemia</i> DUE TO (OR AS A CONSEQUENCE OF):													
b. <i>systemic candida</i> DUE TO (OR AS A CONSEQUENCE OF):													
c. <i>lymphoma</i> DUE TO (OR AS A CONSEQUENCE OF):													
d.													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>liver failure renal failure, gastrointestinal bleeding, pulmonary failure, hyperkalemia</i>													
24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Michael Kopreski MD</i>						29c. LICENSE NUMBER D46720		29d. DATE SIGNED (Month, Day, Year) 4-21-95					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MICHAEL KOPRESKI, MD, 501 W 7TH ST, Frederick MD 21701													
31. DATE FILED (Month, Day, Year) APR 28 1995				32. REGISTRAR'S SIGNATURE <i>Juli Anderson-Randall</i>									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13549

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Robert Jones</i>				2. DATE OF DEATH MONTH <i>4</i> DAY <i>22</i> YEAR <i>95</i>		3. TIME OF DEATH <i>2056</i> M	
4. SOCIAL SECURITY NUMBER <i>248-14-2353</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>76</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>JUNE 4 1918</i>	
8. BIRTHPLACE (State or Foreign Country) <i>SOUTH CAROLINA</i>				9a. FACILITY NAME (If not institution, give street and number) <i>ANNE ARUNDEL MEDICAL CENTER</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>ANNAPOLIS</i>	
9c. COUNTY OF DEATH <i>ANNE ARUNDEL</i>				10a. STATE <i>MARYLAND</i>		10b. COUNTY <i>ANNE ARUNDEL</i>	
10c. CITY, TOWN OR LOCATION <i>ANNAPOLIS</i>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <i>701 GLENWOOD ST. APT. 508</i>	
10f. ZIP CODE <i>21401</i>				10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>BLACK</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>8th</i> College (1-4 or 5+) <i></i>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>LABORER</i>		16b. KIND OF BUSINESS/INDUSTRY <i>U.S. NAVAL ACADEMY</i>	
17. FATHER'S NAME (First, Middle, Last) <i>RALEIGH JONES</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>ROSANNA</i>			
19a. INFORMANT'S NAME (Type/Print) <i>KATHERINE BARLOW</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>3405 W. FOREST PARK AVE. BALTIMORE, MD. 21216</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>4/28/95</i>		20c. LOCATION — City or Town, State <i>ANNAPOLIS, MD.</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Larry H. Reese</i>				22. NAME AND ADDRESS OF FACILITY <i>REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Ventricular Fibrillation Arrest</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>Cardiomyopathy / Cardiogenic shock</i> <i>Pulmonary Fibrosis</i> Approximate Interval Between Onset and Death <i>40 min</i>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/></i>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dennis M. Hall, M.D.</i>				29c. LICENSE NUMBER <i>MD - D41216</i>		29d. DATE SIGNED (Month, Day, Year) <i>4-22-95</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Dennis M. Hall, M.D. 1204 West St., Annapolis, Md</i>							
31. DATE FILED (Month, Day, Year) <i>APR 27 1995</i>				32. REGISTRAR'S SIGNATURE <i>John Andrew Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

AMENDED #10 4/12/95 ELM PG County

95 13550

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

10 0/10

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) HELEN LOUISE JACKSON				2. DATE OF DEATH MONTH DAY YEAR APR 7 1995		3. TIME OF DEATH A M 4:54 A	
4. SOCIAL SECURITY NUMBER 135-20-9845		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 65 YRS.		7. DATE OF BIRTH (Month, Day, Year) May 7, 1929	
9a. FACILITY NAME (If not institution, give street and number) NATIONAL NAVAL MEDICAL CENTER				9b. CITY, TOWN OR LOCATION OF DEATH BETHESDA		9c. COUNTY OF DEATH MONTGOMERY	
10a. STATE MARYLAND				10b. COUNTY CALVERT		10c. CITY, TOWN OR LOCATION DUNKIRK	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
10e. STREET AND NUMBER 12440 UNCLE CHARLIE SPUR				10f. ZIP CODE 20754		10g. CITIZEN OF WHAT COUNTRY? UNITED STATES	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) PROCUREMENT ANALYST RET		16b. KIND OF BUSINESS/INDUSTRY U. S. COMMERCE DEPT.			
17. FATHER'S NAME (First, Middle, Last) MATTHEW J. WINCHESTER				18. MOTHER'S NAME (First, Middle, Maiden Surname) ETHEL MOORE			
19a. INFORMANT'S NAME (Type/Print) GRAHAM L. JACKSON				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12440 UNCLE CHARLIE SPUR, DUNKIRK, MD, 20754			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) CEDAR HILL CEMETERY		DATE 4/13		20c. LOCATION — City or Town, State SUITLAND, MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Alex S. Pope</i> M859				22. NAME AND ADDRESS OF FACILITY ALEXANDER S. POPE FUNERAL HOMES 5538 MARLBORO PIKE, FORESTVILLE, MD 20747			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. METASTATIC SMALL CELL LUNG CANCER DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate interval Between Onset and Death 1 year
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. DESCRIBE HOW INJURY OCCURRED			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>T S Kneff MD</i>				29c. LICENSE NUMBER D-43700		29d. DATE SIGNED (Month, Day, Year) 04/07/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) T S KNEFF, LCDR, MC, USNR BETHESDA MD 20889-5600							
31. DATE FILED (Month, Day, Year) APR 12 1995				32. REGISTRAR'S SIGNATURE <i>John A. Anderson</i>			

95 13551

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARY JULIA JENKINS				2. DATE OF DEATH MONTH 04 DAY 06 YEAR 95		3. TIME OF DEATH 4:15 P.M.	
4. SOCIAL SECURITY NUMBER 579-42-1489		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 89 YRS.		7. DATE OF BIRTH (Month, Day, Year) 7/29/05	
8. BIRTHPLACE (State or Foreign Country) Georgia				9. COUNTY OF DEATH PG			
9a. FACILITY NAME (If not institution, give street and number) Pineview Nursing Home (Pineview Manor)				9b. CITY, TOWN OR LOCATION OF DEATH Clinton		9c. COUNTY OF DEATH PG	
RESIDENCE OF DECEDENT							
10a. STATE DC		10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION Washington		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 419 Madison St NW				10f. ZIP CODE 20011		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 12 Yrs College (1-4 or 5+) None				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Teacher's Aide/Domestic		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) Ben Jones				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary L. Sheffield			
19a. INFORMANT'S NAME (Type/Print) Benjamin T. Jenkins				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 504 47th Place NE, DC 20019			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Maryland Memorial Park 4/15/95		20c. LOCATION — City or Town, State Laurel, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Robert L. P...				22. NAME AND ADDRESS OF FACILITY 318 John T. Rhines Co., Inc. 3030 12th St NE, DC 20017			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. Acute Pulmonary edema DUE TO (OR AS A CONSEQUENCE OF):				Approximate Interval Between Onset and Death 2 hr	
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. Arteriosclerosis of Heart DUE TO (OR AS A CONSEQUENCE OF):				24 hrs	
		c. Dilated Below knee Arteriosclerosis DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Dr. [Signature]				29c. LICENSE NUMBER 24535		29d. DATE SIGNED (Month, Day, Year) 4/6/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 1328 Southern Ave SE Wash DC 20032							
31. DATE FILED (Month, Day, Year) APR 10 1995				32. REGISTRAR'S SIGNATURE John Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Page 12

Page 12

95 13552

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) BARBARA JO JOHNSON				2. DATE OF DEATH MONTH DAY YEAR APRIL 18, 1995		3. TIME OF DEATH 04:30 AM	
4. SOCIAL SECURITY NUMBER 367-36-7205		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 60 YRS.		7. DATE OF BIRTH (Month, Day, Year) Mar 28, 1935	
9a. FACILITY NAME (If not institution, give street and number) SACRED HEART HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH CUMBERLAND		9c. COUNTY OF DEATH ALLEGANY	
RESIDENCE OF DECEDENT							
10a. STATE WV		10b. COUNTY Mineral		10c. CITY, TOWN OR LOCATION Keyser		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER Route 2 Box 144 C				10f. ZIP CODE 26726		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) Anderson Elswick				18. MOTHER'S NAME (First, Middle, Maiden Surname) Myrtle Kinney			
19a. INFORMANT'S NAME (Type/Print) Robert E. Johnson				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Route 2 Box 144 C; Keyser, WV 26726			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Smithsburg Crematorium 04/19		20c. LOCATION — City or Town, State Smithsburg, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Gares F. Scarpelli</i>				22. NAME AND ADDRESS OF FACILITY Scarpelli Funeral Home Cumberland, MD 21502			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → RESPIRATORY FAILURE DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. CARCINOMA OF LUNG WITH pulmonary DUE TO (OR AS A CONSEQUENCE OF): c. BONE METASTASES- DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate Interval Between Onset and Death 15 days 5 MONTHS	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CARCINOMA OF THE FLOOR OF THE MOUTH						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>S. Chang M.D.</i>				29c. LICENSE NUMBER D25638		29d. DATE SIGNED (Month, Day, Year) APRIL 18, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SATURNINA J. CHANG M.D. FROSTBURG PLAZA FROSTBURG MD 21532							
31. DATE FILED (Month, Day, Year) APR 19 1995				32. REGISTRAR'S SIGNATURE <i>J. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

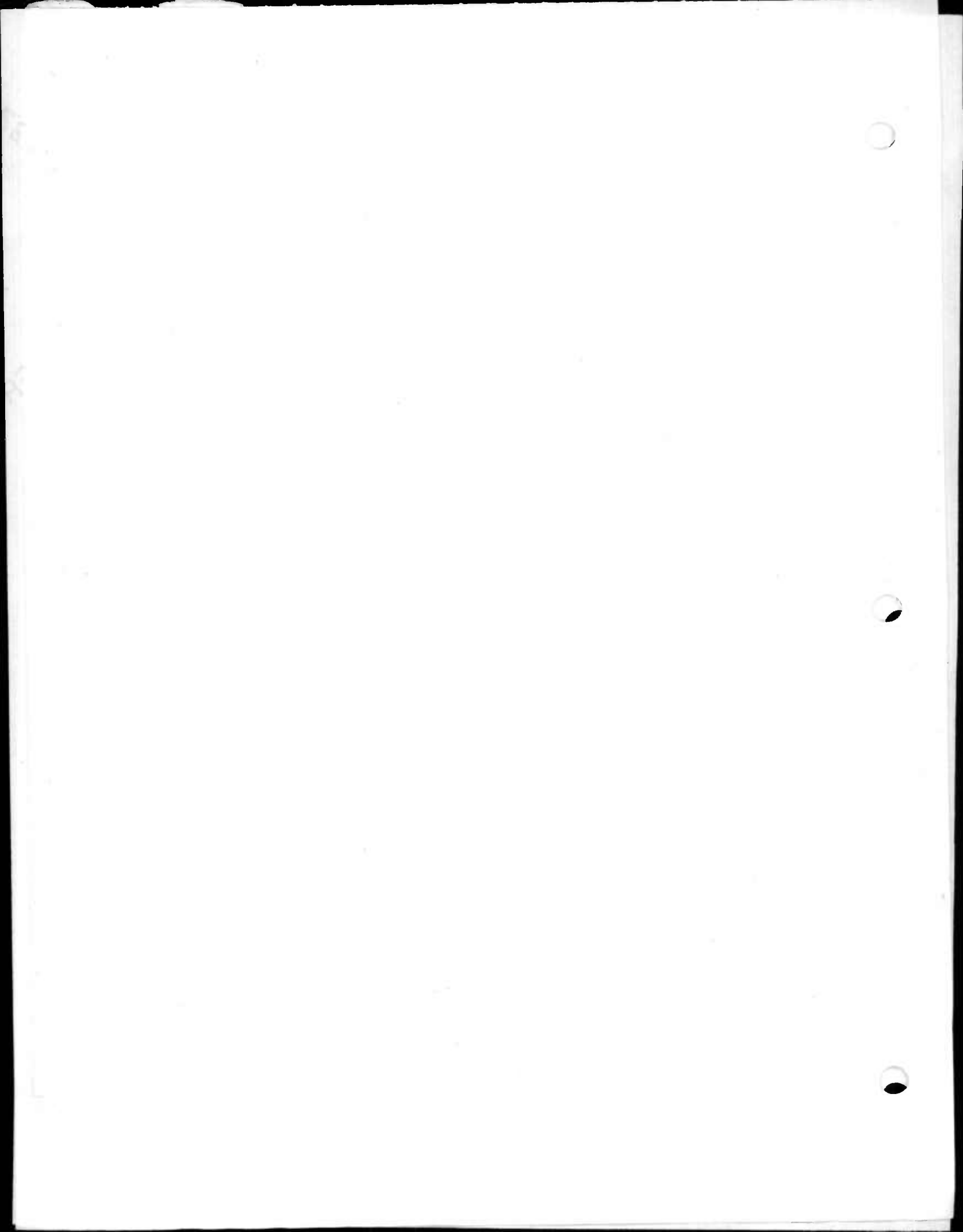
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 13553

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JOHN MADISON JOHNSON				2. DATE OF DEATH MONTH APRIL DAY 19 YEAR 1995		3. TIME OF DEATH 6:30 A M	
4. SOCIAL SECURITY NUMBER 242-28-1973		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 68 YRS.		7. DATE OF BIRTH (Month, Day, Year) Jan. 1, 1927	
9a. FACILITY NAME (If not institution, give street and number) 964 Valley Road				9b. CITY, TOWN OR LOCATION OF DEATH Knoxville		9c. COUNTY OF DEATH Washington	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Washington		10c. CITY, TOWN OR LOCATION Knoxville		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 964 Valley Road				10f. ZIP CODE 21758		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES March 1943 to Dec. 1945		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) Office co-ordinator		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Office co-ordinator		15b. KIND OF BUSINESS/INDUSTRY U.S. Government			
17. FATHER'S NAME (First, Middle, Last) Jacob Luther Johnson				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ida Bell Goins			
19a. INFORMANT'S NAME (Type/Print) Eva C. Johnson				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 964 Valley Road, Knoxville, Md. 21758			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Smithsburg Crematory April 22, 1995		20c. LOCATION — City or Town, State Smithsburg, Maryland		20d. DATE April 22, 1995	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Richard C. C. Basford</i> #00021				22. NAME AND ADDRESS OF FACILITY Keeney and Basford Funeral Home 106 East Church St., Frederick, Md. 21701			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → LUNG CANCER Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death 10 mos							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> A <input type="checkbox"/> P <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Wayne Allgaier MD</i>				29c. LICENSE NUMBER 016675		29d. DATE SIGNED (Month, Day, Year) 4/19/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) WAYNE ALLGAIER, BRUNSWICK, MD 21716							
31. DATE FILED (Month, Day, Year) APR 21 1995		32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13554

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) HAZEL JEANETTA KNIGHT				2. DATE OF DEATH MONTH DAY YEAR APRIL 16, 1995		3. TIME OF DEATH 0445 M	
4. SOCIAL SECURITY NUMBER 218-80-9344		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (in yrs. last birthday) 85 YRS.	7. DATE OF BIRTH (Month, Day, Year) December 28, 1909		8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER				9b. CITY, TOWN OR LOCATION OF DEATH SALISBURY		9c. COUNTY OF DEATH WICOMICO	
10a. STATE Maryland		10b. COUNTY Wicomico		10c. CITY, TOWN OR LOCATION Parsonsborg		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 32544 Longridge Rd.				10f. ZIP CODE 21849		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) Bruce Garfield MacAuley				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Alice Jones			
19a. INFORMANT'S NAME (Type/Print) Bonnie Foley				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 32577 Longridge Rd., Parsonsborg, MD 21849			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Salisbury Crematory		20c. LOCATION — City or Town, State 4/17 Salisbury, MD 21801			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John N. Holloway</i>				22. NAME AND ADDRESS OF FACILITY Holloway Funeral Home 501 Snow Hill Rd., Salisbury, MD 21801			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Pneumonia</i> DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Cerebrovascular accident</i>						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>J. L. Coker, MD</i>		29c. LICENSE NUMBER D25679		29d. DATE SIGNED (Month, Day, Year) 4/16/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) W A Coker, MD 100 Power St, Salisbury, MD 21801							
31. DATE FILED (Month, Day, Year) APR 18 1995		32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>					

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

95 13555

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) John K. Killian				2. DATE OF DEATH MONTH DAY YEAR April 25 1995		3. TIME OF DEATH 12:15am M	
4. SOCIAL SECURITY NUMBER 235-50-6745		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 61 YRS.		7. DATE OF BIRTH (Month, Day, Year) April 5, 1934	
8. BIRTHPLACE (State or Foreign Country) W. Va.				9a. FACILITY NAME (If not institution, give street and number) 393 Jay Bea Ct.		9b. CITY, TOWN OR LOCATION OF DEATH Glen Burnie	
9c. COUNTY OF DEATH Anne Arundel				10a. STATE MD		10b. COUNTY Anne Arundel	
10c. CITY, TOWN OR LOCATION Glen Burnie				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 393 Jay Bea Ct.	
10f. ZIP CODE 21061				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Teacher				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Teacher		16b. KIND OF BUSINESS/INDUSTRY Education	
17. FATHER'S NAME (First, Middle, Last) Jake Shelby Killian				18. MOTHER'S NAME (First, Middle, Maiden Surname) Dortha Evelyn Knapp			
19a. INFORMANT'S NAME (Type/Print) Twila Killian				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 393 Jay Bea Ct. Glen Burnie, MD 21061			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MD Veterans Cem. 4/28		20c. LOCATION — City or Town, State Crownsville, Md	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY 495 Ritchie Hwy. Barranco FH Severna Park, MD 21146			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Lung Cancer Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. DESCRIBE HOW INJURY OCCURRED			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D/150P		29d. DATE SIGNED (Month, Day, Year) 4/27/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Charles J. Wu, M.D. 1600 S Craia Hwy #306 Glen Burnie, Md 21061							
31. DATE FILED (Month, Day, Year) APR 27 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13556

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Margaret Ellen Keeney				2. DATE OF DEATH MONTH 04 DAY 26 YEAR 95		3. TIME OF DEATH 4:07 P M	
4. SOCIAL SECURITY NUMBER 212-24-3569		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 76 YRS.		7. DATE OF BIRTH (Month, Day, Year) 7/10/1918	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) Westminster Nursing Home		9b. CITY, TOWN OR LOCATION OF DEATH Westminster	
9c. COUNTY OF DEATH Carroll				10a. STATE Maryland		10b. COUNTY Carroll	
10c. CITY, TOWN OR LOCATION Westminster				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 45 John Owings Road	
10f. ZIP CODE 21158				10g. CITIZEN OF WHAT COUNTRY? United States		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 8 College (1-4 or 5+) 8				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) worker		16b. KIND OF BUSINESS/INDUSTRY Black & Decker	
17. FATHER'S NAME (First, Middle, Last) Joseph Clarence Stocksdales				18. MOTHER'S NAME (First, Middle, Maiden Surname) Margaret Hannah Smithson			
19a. INFORMANT'S NAME (Type/Print) Judy Ann Owings				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 45 John Owings Road, Westminster, MD 21158			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Evergreen Memorial Gardens 4/28/95 DATE		20c. LOCATION — City or Town, State Finksburg, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Katharine Pitts - Sweitzer</i>				22. NAME AND ADDRESS OF FACILITY Pritts Funeral Home & Chapel 412 Washington Rd., Westminster, MD			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. BRAIN GLIOMASTOMA DUE TO (OR AS A CONSEQUENCE OF): Approximate interval Between Onset and Death 3 YEARS Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Daniel I Welliver MD</i>				29c. LICENSE NUMBER DU496		29d. DATE SIGNED (Month, Day, Year) 4-26-95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DANIEL I WELLIVER MD, WESTMINSTER MD							
31. DATE FILED (Month, Day, Year) APR 27 1995				32. REGISTRAR'S SIGNATURE <i>Julia Duckworth Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.




TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13557

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Geraldine NMN Kuhn				2. DATE OF DEATH MONTH April DAY 24 YEAR 1995		3. TIME OF DEATH 10:20P M	
4. SOCIAL SECURITY NUMBER 214-34-4498		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 76 YRS.		7. DATE OF BIRTH (Month, Day, Year) 01-26-1919	
8a. FACILITY NAME (If not institution, give street and number) Lorien-Riverside Nursing Home				8b. CITY, TOWN OR LOCATION OF DEATH Belcamp		8c. COUNTY OF DEATH Harford	
RESIDENCE OF DECEDENT							
10a. STATE MD		10b. COUNTY Harford		10c. CITY, TOWN OR LOCATION Havre de Grace		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 829 Ontario Street				10f. ZIP CODE 21078		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) 		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Home			
17. FATHER'S NAME (First, Middle, Last) Robert Jesse Crawford				18. MOTHER'S NAME (First, Middle, Maiden Surname) Lucile Ellen Stuart			
19a. INFORMANT'S NAME (Type/Print) Mr. Richard W. Crawford				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 829 Ontario St., Havre de Grace, MD 21078			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Brookview Cemetery		OATE 4/27		20c. LOCATION — City or Town, State Rising Sun, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Mitchell-Smith Funeral Home, P.A. Havre de Grace, MD 21078-3197			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. Septicemia DUE TO (OR AS A CONSEQUENCE OF):					Approximate Interval Between Onset and Death 1 Week
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. Urinary Tract Infection DUE TO (OR AS A CONSEQUENCE OF):					3 Weeks
		c. Pneumonia DUE TO (OR AS A CONSEQUENCE OF):					1 Week
		d.					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURRED			
				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER  MD.				29c. LICENSE NUMBER D32609		29d. DATE SIGNED (Month, Day, Year) April 25, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Kamrudin Mithani, M.D., 703 Revolution St., Havre de Grace, MD 21078							
31. DATE FILED (Month, Day, Year) APR 26 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13558

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Russell Madison Keister				2. DATE OF DEATH MONTH March DAY 30 YEAR 1995		3. TIME OF DEATH 6:30 P. M	
4. SOCIAL SECURITY NUMBER 220-10-0715		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 79 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Oct. 10, 1915	
8. BIRTHPLACE (State or Foreign Country) West Virginia				9a. FACILITY NAME (If not institution, give street and number) 4119 56th Avenue		9b. CITY, TOWN OR LOCATION OF DEATH Bladensburg	
9c. COUNTY OF DEATH Prince George's				10a. STATE Maryland		10b. COUNTY Prince George's	
10c. CITY, TOWN OR LOCATION Bladensburg				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 4119 56th Avenue	
10f. ZIP CODE 20710				10g. CITIZEN OF WHAT COUNTRY? United States		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES World War II				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Painter		16b. KIND OF BUSINESS/INDUSTRY Painting Company	
17. FATHER'S NAME (First, Middle, Last) Robert Keister				18. MOTHER'S NAME (First, Middle, Maiden Surname) Emma Kline			
19a. INFORMANT'S NAME (Type/Print) Clara B. Keister				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4119 56th Avenue, Bladensburg, Maryland 20710			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Fort Lincoln Cemetery 4/4/95		20c. LOCATION — City or Town, State Brentwood, Maryland		21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Lisa S. Grant</i>	
22. NAME AND ADDRESS OF FACILITY Fort Lincoln Funeral Home, Inc. 3401 Bladensburg Rd., Brentwood, MD 20722				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. Advance Carcinoma of the Prostate DUE TO (OR AS A CONSEQUENCE OF): b. Hypertension DUE TO (OR AS A CONSEQUENCE OF): c. Chronic Renal Insufficiency DUE TO (OR AS A CONSEQUENCE OF): d. Anemia Approximate Interval Between Onset and Death 4 yrs 2 yrs 1 mo 1 mo			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>M. Baig MD</i>				29c. LICENSE NUMBER 814216		29d. DATE SIGNED (Month, Day, Year) 3/31/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Mahmoodullah Baig, M.D., 6510 Kenilworth Avenue, #1400, Riverdale, MD 20737							
31. DATE FILED (Month, Day, Year) APR 10 1995				32. REGISTRAR'S SIGNATURE <i>Julia Davidson Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13559

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) William Andrew King				2. DATE OF DEATH MONTH DAY YEAR April 11, 1995		3. TIME OF DEATH 5:45 a m	
4. SOCIAL SECURITY NUMBER 577-38-1120		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 65 YRS.		7. DATE OF BIRTH (Month, Day, Year) Sept. 26, 1929	
8. BIRTHPLACE (State or Foreign Country) New Jersey		9a. FACILITY NAME (If not institution, give street and number) Golden Oaks Nursing Home		9b. CITY, TOWN OR LOCATION OF DEATH Laurel		9c. COUNTY OF DEATH Prince George's	
10a. STATE Maryland		10b. COUNTY Prince George's		10c. CITY, TOWN OR LOCATION Laurel		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 9001 Cherry Lane				10f. ZIP CODE 20708		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Landscaping		16b. KIND OF BUSINESS/INDUSTRY Landscaping Industry			
17. FATHER'S NAME (First, Middle, Last) Ephraim Zacharias King				18. MOTHER'S NAME (First, Middle, Maiden Surname) Willie Lee Mays			
19a. INFORMANT'S NAME (Type/Print) Wanda Costanzo				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4413 75th Avenue, Landover Hills, Maryland 20784			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MD State Veterans Cem. 4/14/95		20c. LOCATION — City or Town, State Cheltenham, Maryland		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE W.B. Gesser				22. NAME AND ADDRESS OF FACILITY Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pulmonary Embolus Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. Metastatic Laryngeal cancer c. d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Obstructive Pulmonary Disease							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Jenny Y. Moy				29c. LICENSE NUMBER D43260		29d. DATE SIGNED (Month, Day, Year) April 12, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Jenny Y. Moy, MD 14333 Laurel Bowie Rd #307 Laurel MD 20708							
31. DATE FILED (Month, Day, Year) APR 13 1995				32. REGISTRAR'S SIGNATURE Julia Anderson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



20-10-2010 10:00 AM 20-10-2010

95 13560

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ANNA ROSE KING				2. DATE OF DEATH MONTH APRIL DAY 19 YEAR 1995		3. TIME OF DEATH 09:15 A^M	
4. SOCIAL SECURITY NUMBER 214-05-4823		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 91 YRS.		7. DATE OF BIRTH (Month, Day, Year) FEB 5 1904	
9a. FACILITY NAME (If not institution, give street and number) SACRED HEART HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH CUMBERLAND				9c. COUNTY OF DEATH ALLEGANY	
10a. STATE MARYLAND		10b. COUNTY ALLEGANY		10c. CITY, TOWN OR LOCATION LAVALE		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 6 ROGER WAY				10f. ZIP CODE 21502		10g. CITIZEN OF WHAT COUNTRY? U S A	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER		16b. KIND OF BUSINESS/INDUSTRY OWN HOME			
17. FATHER'S NAME (First, Middle, Last) JOHN D. FARRELL				18. MOTHER'S NAME (First, Middle, Maiden Surname) MARY ROSELLA MCATEE			
19a. INFORMANT'S NAME (Type/Print) ROBERT H. KING				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15001 NATIONAL HWY CUMBERLAND, MD 21502			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) ST MARY CEMETERY		DATE APR 22		20c. LOCATION — City or Town, State CUMBERLAND, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Douglas D. Hafner</i>				22. NAME AND ADDRESS OF FACILITY HAFER CHAPEL OF THE HILLS MORTUARY 1302 NATIONAL HWY LAVALE, MD 21502			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <i>Dehydration-malnutrition</i> DUE TO (OR AS A CONSEQUENCE OF):					
		b. <i>Bowel perforation</i> DUE TO (OR AS A CONSEQUENCE OF):					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST		c. <i>Carcinoma, kidney, metastasized widely</i> DUE TO (OR AS A CONSEQUENCE OF):					
		d.					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Ascend - arthritis</i>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>V. Mazzocco</i>		29c. LICENSE NUMBER 007135		29d. DATE SIGNED (Month, Day, Year) APRIL 20, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. VICTOR MAZZOCCO, M.D., 912 SETON DRIVE, CUMBERLAND, MD 21502							
31. DATE FILED (Month, Day, Year) APR 21 1995		32. REGISTRAR'S SIGNATURE <i>John D. Farrell</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13561

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) KATHERINE C. KARLEM				2. DATE OF DEATH MONTH DAY YEAR April 19, 1995				3. TIME OF DEATH 12:45 A.M.			
4. SOCIAL SECURITY NUMBER 577-34-9648		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 97 YRS.		7. DATE OF BIRTH (Month, Day, Year) April 30, 1897		8. BIRTHPLACE (State or Foreign Country) Pennsylvania			
9a. FACILITY NAME (If not institution, give street and number) Meridian Nursing Home				9b. CITY, TOWN OR LOCATION OF DEATH Frederick				9c. COUNTY OF DEATH Frederick			
RESIDENCE OF DECEDENT											
10a. STATE Maryland		10b. COUNTY Frederick		10c. CITY, TOWN OR LOCATION Frederick				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER 618 Wilson Place				10f. ZIP CODE 21702				10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) 10				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Journal office				16b. KIND OF BUSINESS/INDUSTRY Army-Navy			
17. FATHER'S NAME (First, Middle, Last) Peter Kuchesky				18. MOTHER'S NAME (First, Middle, Maiden Surname) Eva Murin							
19a. INFORMANT'S NAME (Type/Print) Catherine K. Graf				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 618 Wilson Place Frederick, Maryland 21702							
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Hagerstown Crematory 4/21/95				20c. LOCATION — City or Town, State Hagerstown, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Larry R. Savage</i>				22. NAME AND ADDRESS OF FACILITY Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike Frederick, MD 21702							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Arteriosclerotic cardiovascular disease</i>											
DUE TO (OR AS A CONSEQUENCE OF):											
b. DUE TO (OR AS A CONSEQUENCE OF):											
c. DUE TO (OR AS A CONSEQUENCE OF):											
d. DUE TO (OR AS A CONSEQUENCE OF):											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Proteinuria</i>											
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TYPE OF CERTIFIER <i>Arthur G. Manalo</i>				29c. LICENSE NUMBER D-18191		29d. DATE SIGNED (Month, Day, Year) 4-19-95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Arthur G. Manalo, M.D. 187 Thomas Johnson Drive Frederick, Maryland 21702											
31. DATE FILED (Month, Day, Year) 4-APR-21 1995				32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.


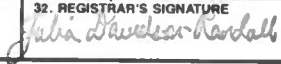
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13562

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Emily Kelton				2. DATE OF DEATH MONTH April DAY 21 YEAR 1995				3. TIME OF DEATH 11:35 a.m.											
4. SOCIAL SECURITY NUMBER 107 - 10 - 7674				5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 97 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS. HOURS 0 MIN. 0		7. DATE OF BIRTH (Month, Day, Year) June 25, 1897		8. BIRTHPLACE (State or Foreign Country) New York					
9a. FACILITY NAME (If not institution, give street and number) North Arundel Hospital								9b. CITY, TOWN OR LOCATION OF DEATH Glen Burnie				9c. COUNTY OF DEATH Anne Arundel							
10a. STATE New York				10b. COUNTY Albany				10c. CITY, TOWN OR LOCATION Albany				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
10e. STREET AND NUMBER 37 Hawthorne Avenue								10f. ZIP CODE 12203				10g. CITIZEN OF WHAT COUNTRY? USA							
11. MARITAL STATUS 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) Grade 12				15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife				15b. KIND OF BUSINESS/INDUSTRY Own Home											
17. FATHER'S NAME (First, Middle, Last) John Beyer								18. MOTHER'S NAME (First, Middle, Maiden Surname) Christine Pfeil											
19a. INFORMANT'S NAME (Type/Print) Charles Jenkins								19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 309 Beech Grove Court, Millersville, MD 21108											
20a. METHOD OF DISPOSITION 4 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Eagle Hill Cemetery				DATE 4/25		20c. LOCATION — City or Town, State Albany, New York									
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 								22. NAME AND ADDRESS OF FACILITY Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Maryland 20707											
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. SEPSIS DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):												Approximate Interval Between Onset and Death 2 days							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>												24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)															
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED							
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)								28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)											
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																			
29b. SIGNATURE AND TITLE OF CERTIFIER Arthur MEDICAL HOUSE OFFICER.								29c. LICENSE NUMBER D43977				29d. DATE SIGNED (Month, Day, Year) April 21st '95							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ANDREW DRETMER, North Arundel Hosp. 301 Hosp. Dr. Glen Burnie MD.																			
31. DATE FILED (Month, Day, Year) APR 27 1995								32. REGISTRAR'S SIGNATURE 											

TO BE COMPLETED BY FUNERAL DIRECTOR

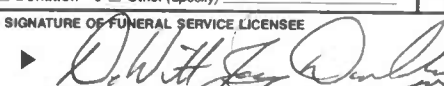

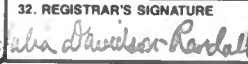
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) PATRICIA KNOTT				2. DATE OF DEATH MONTH APRIL DAY 20 YEAR 95		3. TIME OF DEATH 5:47P M	
4. SOCIAL SECURITY NUMBER 375 - 28 - 3029		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 62 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 23, 1932	
9a. FACILITY NAME (If not institution, give street and number) Howard County General Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Columbia		9c. COUNTY OF DEATH Howard	
10a. STATE Maryland				10b. COUNTY Howard		10c. CITY, TOWN OR LOCATION Ellicott City	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER 3112 Wheaton Way Apt H			
10f. ZIP CODE 21043				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2 Years		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Claims Representative		16b. KIND OF BUSINESS/INDUSTRY Insurance			
17. FATHER'S NAME (First, Middle, Last) Robert Rushford				18. MOTHER'S NAME (First, Middle, Maiden Surname) Theresa Hannan			
19a. INFORMANT'S NAME (Type/Print) Dave Knott				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23049 Cleveland, Dearborn, Michigan 48124			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) St. Hedwig Cemetery		DATE 4/26		20c. LOCATION — City or Town, State Dearborn Heights, MI	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Maryland 20707			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → MYOCARDIAL INFARCTION PROBABLE ARRHYTHMIA DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST HYPERTENSION MITRAL VALVULAR STENOSIS DUE TO (OR AS A CONSEQUENCE OF): DIABETES MELLITUS HYPERTENSION DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death 1 DAY YEARS YEARS							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. "DIABETES MELLITUS" HYPERCHOLESTEROLEMIA DIABETIC ARTERIO- SCLEROSIS, "DIVERTICULOSIS OF THE SIGMOID COLON", "ACUTE BRONCHO- ALVEOLAR PNEUMONIA OF THE LOWER LOBES," MILD CORONARY ATHEROSCLEROSIS". DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D38296		29d. DATE SIGNED (Month, Day, Year) APRIL 21, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JOSEPH F. GIBBONS, MD 9501 OLD ANNAPOLIS RD, ELLICOTT CITY, MD 21042							
31. DATE FILED (Month, Day, Year) APR 27 1995		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13564

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ROBERT L. Kraft				2. DATE OF DEATH MONTH April DAY 18 YEAR 1995		3. TIME OF DEATH 1324 M	
4. SOCIAL SECURITY NUMBER 183-14-8327		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 71 YRS.		7. DATE OF BIRTH (Month, Day, Year) Apr. 6 1924	
8. BIRTHPLACE (State or Foreign Country) Pennsylvania				9a. FACILITY NAME (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER		9b. CITY, TOWN OR LOCATION OF DEATH SALISBURY	
9c. COUNTY OF DEATH WICOMICO				10a. STATE Maryland		10b. COUNTY Somerset	
10c. CITY, TOWN OR LOCATION Princess Anne				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 13308 Pine Beach Road	
10f. ZIP CODE 21853				10g. CITIZEN OF WHAT COUNTRY? U.S.		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Marine Policeman		16b. KIND OF BUSINESS/INDUSTRY State of Maryland	
17. FATHER'S NAME (First, Middle, Last) Ralph L. Kraft, Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Sarah Alice Harbough			
19a. INFORMANT'S NAME (Type/Print) Barbara Parkinson				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13304 Pine Beach Road, Princess Anne, Md. 21853			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Asbury Cemetery		20c. LOCATION — City or Town, State 4/22 Mt. Vernon, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James H. Harmon</i> M00295				22. NAME AND ADDRESS OF FACILITY Hinman Funeral Home Princess Anne, Md. 21853			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cardiac arrest. Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. Resumed myocardial infarction c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death 1/2 hr
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes SIP CVA							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> POA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
29b. SIGNATURE AND TITLE OF CERTIFIER <i>C. Hegman</i> MD		29c. LICENSE NUMBER D 25219		29d. DATE SIGNED (Month, Day, Year) 4-19-95		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) CHARLES STEEDMAN, MD 30434 MT VERNON RD PRINCESS ANNE, MD	
31. DATE FILED (Month, Day, Year) APR 20 1995		32. REGISTRAR'S SIGNATURE <i>John A. ...</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.


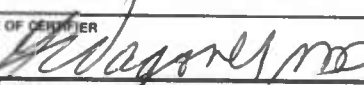
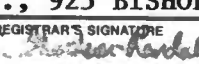
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Amended #2, 4/12/95, N. L. S. Allegany County

95 13565

1 -
FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JAMES LEROY KASMIER				2. DATE OF DEATH MONTH 6 DAY 5 YEAR 1995		3. TIME OF DEATH 0455 A M			
4. SOCIAL SECURITY NUMBER 235-54-8252		5. SEX 1 <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 60 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 16 1934		8. BIRTHPLACE (State or Foreign Country) WV	
9a. FACILITY NAME (If not institution, give street and number) Sacred Heart Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Cumberland			9c. COUNTY OF DEATH Allegany		
RESIDENCE OF DECEDENT									
10a. STATE MD		10b. COUNTY Allegany		10c. CITY, TOWN OR LOCATION McCoole			10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
10e. STREET AND NUMBER 75 Queen Street				10f. ZIP CODE 21562		10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 2 <input checked="" type="checkbox"/> Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) 11 Elementary/Secondary (0-12) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Truck Driver			16b. KIND OF BUSINESS/INDUSTRY Concrete Manufacturing		
17. FATHER'S NAME (First, Middle, Last) Franklin Rudolph Kasmier				18. MOTHER'S NAME (First, Middle, Maiden Surname) Viola Susan Smiley					
19a. INFORMANT'S NAME (Type/Print) Edna B. Kasmier				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 75 Queen Street McCoole, MD 21562					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Potomac Memorial Gardens 4/9/95			DATE 4/9/95		20c. LOCATION — City or Town, State Keyser, WV 26726		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Rotruck-Smith Funeral Home 85 South Main Street Keyser, WV 26726					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. End-stage Metastatic Adenocarcinoma of Prostate DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death: 2 yrs									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER  DR. GARY WAGONER, M.D., 925 BISHOP WALSH ROAD, CUMBERLAND, MD 21502				29c. LICENSE NUMBER D22181		29d. DATE SIGNED (Month, Day, Year) APRIL 6, 1995			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. GARY WAGONER, M.D., 925 BISHOP WALSH ROAD, CUMBERLAND, MD 21502				31. DATE FILED (Month, Day, Year) APR 12 1995					
32. REGISTRAR'S SIGNATURE 									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS, P.O. BOX 68760
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 13566

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Oliver Lecates				2. DATE OF DEATH MONTH DAY YEAR April 10, 1995				3. TIME OF DEATH 2:55 pm	
4. SOCIAL SECURITY NUMBER 218-34-9833		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 81 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 12-9-1913		8. BIRTHPLACE (State or Foreign Country) Md.	
9a. FACILITY NAME (If not institution, give street and number) Deer's Head Center				9b. CITY, TOWN OR LOCATION OF DEATH Salisbury			9c. COUNTY OF DEATH Wicomico		
RESIDENCE OF DECEDENT									
10a. STATE Md.		10b. COUNTY Wicomico		10c. CITY, TOWN OR LOCATION Delmar			10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
10e. STREET AND NUMBER 30595 Gordy Mill Road				10f. ZIP CODE 21875		10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) 			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Farmer			16b. KIND OF BUSINESS/INDUSTRY Grain & Vegetables			
17. FATHER'S NAME (First, Middle, Last) Rola J. Lecates				18. MOTHER'S NAME (First, Middle, Maiden Surname) Virtie Elliott Lecates					
19a. INFORMANT'S NAME (Type/Print) Lois R. Twilley				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 31720 Dagsboro Road, Delmar, Md. 21875					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Springhill Memory Gardens 4-13		DATE Hebron, Md.		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>William M. Short</i>				22. NAME AND ADDRESS OF FACILITY Short Funeral Home, Inc. 13 E. Grove St. Delmar, De. 19940					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → End stage renal disease and congeative heart failure DUE TO (OR AS A CONSEQUENCE OF): 5 years Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { Systemic lupus erythematosus DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):								Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying causes given in Part I. Hypertension								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>M. Shrestha M.D.</i>				29c. LICENSE NUMBER D16278		29d. DATE SIGNED (Month, Day, Year) 4/10/95			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) M. Shrestha, M.D., Deer's Head Center, P. O. Box 2018, Salisbury, MD									
31. DATE FILED (Month, Day, Year) APR 14 1995		32. REGISTRAR'S SIGNATURE <i>Julia Davidson Randall</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

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IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1900

95 13567

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Mary D. Linton				2. DATE OF DEATH MONTH April DAY 15, YEAR 1995		3. TIME OF DEATH 8:35 a. M	
4. SOCIAL SECURITY NUMBER 213-05-1963		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 97 YRS.		7. DATE OF BIRTH (Month, Day, Year) 10/25/1897	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) Edw.W.McCready Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Crisfield	
9c. COUNTY OF DEATH Somerset				RESIDENCE OF DECEDENT			
10a. STATE Maryland		10b. COUNTY Worcester		10c. CITY, TOWN OR LOCATION Pocomoke City		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 1830 Cedar Hall Road				10f. ZIP CODE 21851		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Seamstress		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) Henry Frank Adams				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Virginia Sterling			
19a. INFORMANT'S NAME (Type/Print) Margaret Buchanan				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1826 Cedar Hall Rd., Pocomoke City, Md. 21851			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) First Baptist Cemetery		DATE 4/18		20c. LOCATION — City or Town, State Pocomoke City, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Scott S. Melson</i>				22. NAME AND ADDRESS OF FACILITY Melson Funeral Home PO BOX 64, Pocomoke City, Md. 21851			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. CVA, nonhemorrhagic infarct Rt Parietal 9 days					
		b. Atherosclerotic Cerebrovascular Disease 5 yrs					
		c. Generalized Atherosclerosis 5 yrs					
		d.					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Arteriosclerotic Heart Disease</i> <i>Gastroenteritis</i> <i>Anorexia</i>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Gregorio M. Bellosso M.D.</i>				29c. LICENSE NUMBER D29505		29d. DATE SIGNED (Month, Day, Year) 04-15-95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) GREGORIO M. BELLOSO, 4421 BEECHWOOD PL, CRISFIELD, MD 21817							
31. DATE FILED (Month, Day, Year) APR 21 1995		32. REGISTRAR'S SIGNATURE <i>John Anderson</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

21/1/21

20th Nov

95 13568

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) WILLIAM AUGUST LEHNERT Jr.				2. DATE OF DEATH MONTH 4 DAY 23 YEAR 95		3. TIME OF DEATH 2055 M	
4. SOCIAL SECURITY NUMBER 215-10-4090		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 81 YRS.		7. DATE OF BIRTH (Month, Day, Year) 4/13/1914	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) Carroll County Gn. Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Westminster	
9c. COUNTY OF DEATH Carroll				10a. STATE Maryland		10b. COUNTY Carroll	
10c. CITY, TOWN OR LOCATION Westminster				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 1029 Hook Road	
10f. ZIP CODE 21157				10g. CITIZEN OF WHAT COUNTRY? United States		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yea or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+) supervisor				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) supervisor		16b. KIND OF BUSINESS/INDUSTRY Western Electric Co.	
17. FATHER'S NAME (First, Middle, Last) William August Lehnert Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Sadie Lice			
19a. INFORMANT'S NAME (Type/Print) Alice S. Lehnert				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1029 Hook Road, Westminster, MD 21157			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Westminster Cemetery 4/26/95		20c. LOCATION — City or Town, State Westminster, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Katharine Pritts - Switzer				22. NAME AND ADDRESS OF FACILITY Pritts Funeral Home & Chapel 412 Washington Rd., Westminster, MD			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → MACRONODULAR CIRRHOSIS OF LIVER DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { HEPATITIS B DUE TO (OR AS A CONSEQUENCE OF): BLOOD TRANSFUSION DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIGOXIN TOXICITY, ATRIAL FIBRILLATION							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) N/A		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Thomas K. Galvin M.D.				29c. LICENSE NUMBER D31660		29d. DATE SIGNED (Month, Day, Year) 4/24/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) THOMAS K. GALVIN MD 542 WASHINGTON RD WESTMINSTER MD 21157							
31. DATE FILED (Month, Day, Year) APR 26 1995		32. REGISTRAR'S SIGNATURE Julia P. [Signature]					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 YEAR

MACRONODULAR CIRRHOSIS OF LIVER

DOYASZ

HEPATITIS B

BLOOD TRANSFUSION

95-1812-033

DWG

Item, 27 per MEO - Local Health Dept. P.G., GC, 4/10/95

95 13569

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last) CATHERINE				2. DATE OF DEATH MONTH DAY YEAR MARCH 29 95				3. TIME OF DEATH 6:00P M	
4. SOCIAL SECURITY NUMBER 233-36-9336		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 68 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) January 19, 1927	
8. BIRTHPLACE (State or Foreign Country) Charleston, West Virginia				9. FACILITY NAME (If not institution, give street and number) WASHINGTON ADVENTIST HOSPITAL				10. CITY, TOWN OR LOCATION OF DEATH TAKOMA PARK	
11. RESIDENCE OF DECEDENT 10a. STATE Maryland				10b. COUNTY Prince George's		10c. CITY, TOWN OR LOCATION Hyattsville		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 5616 30th Avenue				10f. ZIP CODE 20782		10g. CITIZEN OF WHAT COUNTRY? United States of America			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, OIYE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No - If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE - American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Switchboard Operator		16b. KIND OF BUSINESS/INDUSTRY Giant Food Corporation					
17. FATHER'S NAME (First, Middle, Last) John Howard Cummings				18. MOTHER'S NAME (First, Middle, Maiden Surname) Leona V. Kesler					
19a. INFORMANT'S NAME (Type/Print) Timothy A. Corley				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 40-C Crescent Road, Greenbelt, Maryland 20770					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) High Lawn Memorial Park 4/3/95		20c. LOCATION - City or Town, State Oak Hill, West Virginia					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE #M00690 <i>David A. Carson</i>				22. NAME AND ADDRESS OF FACILITY Tyree Funeral Home 999 Jones Avenue, Oak Hill, WV 25901					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Arteriosclerotic cardiovascular disease Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>David A. Carson MD</i>		29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) MARCH 30/95			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J. ARON WICK, MD 111 PENN STREET, BALTIMORE, MARYLAND 21201									
31. DATE FILED (Month, Day, Year) APR 10 1995				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>					

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020
DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95-1935-510
B.K.S

ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-723 5/19/95 t.t

95 13570

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) WILLIAM A. LASTER				2. DATE OF DEATH MONTH DAY YEAR APRIL 06 1995		3. TIME OF DEATH 0930 A.M.					
4. SOCIAL SECURITY NUMBER 220-62-6561		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 40 YRS.		7. DATE OF BIRTH (Month, Day, Year) August 31, 1954		8. BIRTHPLACE (State or Foreign Country) North Carolina			
9a. FACILITY NAME (If not institution, give street and number) DEATON MEDICAL CENTER				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY				9c. COUNTY OF DEATH			
10a. STATE Maryland		10b. COUNTY Prince George's		10c. CITY, TOWN OR LOCATION Brandywine				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER 6804 Burchhill Road				10f. ZIP CODE 20613		10g. CITIZEN OF WHAT COUNTRY? U.S.A.					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Truck Driver		15b. KIND OF BUSINESS/INDUSTRY Self-Employed							
17. FATHER'S NAME (First, Middle, Last) William Laster				18. MOTHER'S NAME (First, Middle, Maiden Surname) Willie J. McNeill							
19a. INFORMANT'S NAME (Type/Print) Karen Laster (Wife)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2437 Kent Village Place Landover, Maryland 20785							
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery or place of interment) Fort Lincoln Cemetery 4/13/95		20c. LOCATION — City or Town, State Brentwood, Maryland							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY Roth's Funeral Home, Inc. 4339 Hunt Place, N.E. Washington, D.C. 20019							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. STABWOUNDS WITH COMPLICATIONS DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide 5 <input checked="" type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) 3/11/95		28b. TIME OF INJURY 9:55 P.M.		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED SUBJECT WAS STABBED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) HOUSE LOCATED AT				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3143 75TH AVE. LANDOVER, PR. GEO., MD.							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) APRIL 7, 1995			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Maryann A. Koronowski 111 PENN STREET, BALTIMORE, MARYLAND 21201											
31. DATE FILED (Month, Day, Year) APR 13 1995				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>							

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13571

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) DONALD LEO LEWIS				2. DATE OF DEATH MONTH APRIL DAY 11 YEAR 1995		3. TIME OF DEATH 02:05 A M	
4. SOCIAL SECURITY NUMBER 232-48-2065		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 64 YRS.		7. DATE OF BIRTH (Month, Day, Year) Nov. 11, 1930	
8. BIRTHPLACE (State or Foreign Country) WV				9a. FACILITY NAME (If not institution, give street and number) Sacred Heart Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Cumberland	
9c. COUNTY OF DEATH Allegany				10a. STATE WV		10b. COUNTY Hampshire	
10c. CITY, TOWN OR LOCATION Three Churches				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER HC 74 Box 189D	
10f. ZIP CODE 26765				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW11		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+) WW11		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Custodian		16b. KIND OF BUSINESS/INDUSTRY WV School Deaf & Blind			
17. FATHER'S NAME (First, Middle, Last) Lawrence Lewis				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Long			
19a. INFORMANT'S NAME (Type/Print) Christine Shanholtz				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) HC 74 Box 189D Three Churches, WV 26765			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) _____		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Branch Mt. Baptist 4/13		20c. LOCATION — City or Town, State Three Churches, WV			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James R. [Signature]</i>				22. NAME AND ADDRESS OF FACILITY McKee Funeral Home P.O. Box 270 Augusta, WV 26704			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Acute Respiratory Failure DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST COPD DUE TO (OR AS A CONSEQUENCE OF): Severe DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death 2 days 10 yrs.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Severe							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Robert M. Dr. [Signature]</i>				29c. LICENSE NUMBER 054846		29d. DATE SIGNED (Month, Day, Year) APRIL 12, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Orlino, Robert M.D. 902 S. [Address] Cumberland, MD 21502							
31. DATE FILED (Month, Day, Year) APR 20 1995		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

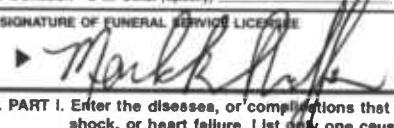

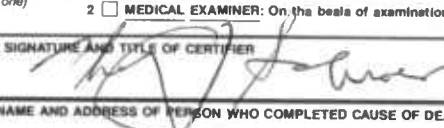
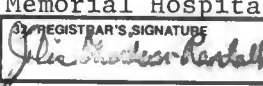
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13572

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ALEX ROBERT LEE, Jr.				2. DATE OF DEATH MONTH DAY YEAR March 27, 1995		3. TIME OF DEATH 6:02 A M	
4. SOCIAL SECURITY NUMBER 703-07-9371		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 69 YRS.		7. DATE OF BIRTH (Month, Day, Year) Jan. 19, 1926	
9a. FACILITY NAME (If not institution, give street and number) Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Cumberland		9c. COUNTY OF DEATH Allegany	
10a. STATE WV		10b. COUNTY Hampshire		10c. CITY, TOWN OR LOCATION Springfield		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER P.O. Box 2				10f. ZIP CODE 26763		10g. CITIZEN OF WHAT COUNTRY? US	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10th		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Welder/boiler Maker		16b. KIND OF BUSINESS/INDUSTRY Railroad			
17. FATHER'S NAME (First, Middle, Last) Alex Robert Lee, Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Nannie Susan Hartman			
19a. INFORMANT'S NAME (Type/Print) Shirley Lee				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 2, Springfield, WV 26763			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Forest Glen Cenetery March 29, 1995		20c. LOCATION — City or Town, State Green Spring, WV			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Shaffer Funeral Home, Inc., 230 E. Main St, Romney, WV 26757			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Ruptured abdominal aortic aneurysm DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. 							Approximate Interval Between Onset and Death 3 hours
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Severe arteriosclerotic cardiovascular disease							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D 17456		29d. DATE SIGNED (Month, Day, Year) APRIL 10, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. P. Schroeder, Memorial Hospital, Cumberland, MD 21502							
31. DATE FILED (Month, Day, Year) APR 13 1995		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

ALINE MITCHELL

95 13573

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ALINE MITCHELL				2. DATE OF DEATH MONTH DAY YEAR April 16 1995		3. TIME OF DEATH 9:50 A M	
4. SOCIAL SECURITY NUMBER 215-12-6152		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 90 YRS.		7. DATE OF BIRTH (Month, Day, Year) 10-14-1904	
8. BIRTHPLACE (State or Foreign Country) SALISBURY				9a. FACILITY NAME (If not institution, give street and number) SALISBURY NURSING & REHAB CENTER		9b. CITY, TOWN OR LOCATION OF DEATH SALISBURY, MD.	
9c. COUNTY OF DEATH WICOMICO				10a. STATE MD.		10b. COUNTY WICOMICO	
10c. CITY, TOWN OR LOCATION SALISBURY				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 1008 N. DIVISION ST.	
10f. ZIP CODE 21801				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> 6				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) TEACHER & LIBRARIAN		16b. KIND OF BUSINESS/INDUSTRY PUBLIC SCHOOL	
17. FATHER'S NAME (First, Middle, Last) WILLIAM WESLEY MITCHELL				18. MOTHER'S NAME (First, Middle, Maiden Surname) LILLY PHIPPS			
19a. INFORMANT'S NAME (Type/Print) LETITIA BATES				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27907 ORIOLE RD. PRINCESS ANNE, MD. 21853			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) PARSONS CEMETERY 4-19		20c. LOCATION — City or Town, State SALISBURY, MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Letitia Bates</i>				22. NAME AND ADDRESS OF FACILITY BOUNDS FUNERAL HOME, SALISBURY, MD			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Congestive Heart Failure</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>HTN</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i>Atherosclerotic Heart Disease</i> DUE TO (OR AS A CONSEQUENCE OF): d. Sequitely ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Dementia</i> <i>Renal Failure</i>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Michael Atkins M.D.</i>				29c. LICENSE NUMBER D-39813		29d. DATE SIGNED (Month, Day, Year) 4/17/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MICHAEL ATKINS, M.D., 1104 HEALTHWAY DR., SALISBURY, MD.							
31. DATE FILED (Month, Day, Year) APR 19 1995				32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Dr. L. J. W. H. 70 + 1014

95 13574

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Lucy B. MacDonnell				2. DATE OF DEATH MONTH April 20, DAY 1995 YEAR		3. TIME OF DEATH 8:20 P.M.	
4. SOCIAL SECURITY NUMBER 214-05-0707		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 80 YRS.		7. DATE OF BIRTH (Month, Day, Year) Nov. 23, 1914	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) Fairfield Nursing Home		9b. CITY, TOWN OR LOCATION OF DEATH Crownsville	
9c. COUNTY OF DEATH Anne Arundel				10a. STATE Maryland		10b. COUNTY Anne Arundel	
10c. CITY, TOWN OR LOCATION Crownsville				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 1454 Fairfield Loop Road	
10f. ZIP CODE 21032				10g. CITIZEN OF WHAT COUNTRY? United States		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Caucasian	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Clerk		16b. KIND OF BUSINESS/INDUSTRY Banking	
17. FATHER'S NAME (First, Middle, Last) Lemon Beall Jr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Lucy Collinson			
19a. INFORMANT'S NAME (Type/Print) Ninian Beall (brother)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 205 Coulbourne Lane Snow Hill, Maryland 21863			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) All Hallows Chapel Cemetery 4-24-95 Davidsonville, Md.			
20c. LOCATION — City or Town, State				21. SIGNATURE OF FUNERAL SERVICE LICENSEE [Signature]			
22. NAME AND ADDRESS OF FACILITY John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, Md. 21401				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → CVA Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST ASCVD PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. NO code			
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 28d. DESCRIBE HOW INJURY OCCURRED 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TYPE OF CERTIFIER [Signature] M.D. 29c. LICENSE NUMBER D-19528 29d. DATE SIGNED (Month, Day, Year) 4-21-95			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Elmo M. Gayoso, M.D. 5411 Old Frederick Rd. Baltimore, Md. (Ph.#410-744-3950)							
31. DATE FILED (Month, Day, Year) APR 25 1995				32. REGISTRAR'S SIGNATURE [Signature]			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13575

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Mary Elsie McGuckian				2. DATE OF DEATH MONTH DAY YEAR April 23 1995		3. TIME OF DEATH 3:15A M	
4. SOCIAL SECURITY NUMBER 220-44-3199		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) YRS. MONTHS DAYS IF UNDER 1 YEAR IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) Nov 10 1902	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) Annapolis Nursing & Rehab Center		9b. CITY, TOWN OR LOCATION OF DEATH Annapolis	
9c. COUNTY OF DEATH Anne Arundel				10a. STATE MD		10b. COUNTY Anne Arundel	
10c. CITY, TOWN OR LOCATION Annapolis				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 602 Burnside Street	
10f. ZIP CODE 21403				10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Home			
17. FATHER'S NAME (First, Middle, Last) Benjamin Leitch				18. MOTHER'S NAME (First, Middle, Maiden Surname) Martha Caterton			
19a. INFORMANT'S NAME (Type/Print) Alfred B. McGuckian				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 602 Burnside Street Annapolis, MD 21403			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) St. Anne's Cemetery 4/26/95		20c. LOCATION — City or Town, State Annapolis, Maryland		21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Donald S. Luyfa</i>	
22. NAME AND ADDRESS OF FACILITY John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cochlexia</i> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. <i>Organic Brain Syndrome</i> c. <i>Demintion</i> d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>George C. Samaras</i>				29c. LICENSE NUMBER D08314		29d. DATE SIGNED (Month, Day, Year) April 24, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) George C. Samaras, M.D. 205 Ridgley Avenue Annapolis, MD 21401 (410-268-3232)							
31. DATE FILED (Month, Day, Year) APR 25 1995				32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13576

#10abcdef. FilmG724 6/13/95 kam

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Marie McCusker</i>				2. DATE OF DEATH MONTH <i>4</i> DAY <i>27</i> YEAR <i>95</i>		3. TIME OF DEATH <i>7:45 AM</i>	
4. SOCIAL SECURITY NUMBER <i>191-32-5146</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>94</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>3-19-1901</i>	
8. BIRTHPLACE (State or Foreign Country) <i>Pennsylvania</i>				9. COUNTY OF DEATH <i>Anne Arundel</i>			
9a. FACILITY NAME (If not institution, give street and number) <i>Knollwood Manor Nursing Ctr.</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Millersville</i>		9c. COUNTY OF DEATH <i>Anne Arundel</i>	
10a. STATE <i>Pa. Md.</i>		10b. COUNTY <i>Anne Arundel Co.</i>		10c. CITY, TOWN OR LOCATION <i>Millersville</i>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <i>Knollwood Manor Nursing Ctr.</i>				10f. ZIP CODE <i>21108</i>		10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>2</i> College (1-4 or 5+) <i>2</i>		18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Teacher</i>		18b. KIND OF BUSINESS/INDUSTRY <i>Elem. School</i>			
17. FATHER'S NAME (First, Middle, Last) <i>John Geary</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Mary Rose Hughes</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Rosemarie DeVal</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>548 Heavitree La. Severna Park, MD 21146</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>St. Josephs Cem. 4/27</i>		20c. LOCATION — City or Town, State <i>E. McKeesport, Pa.</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <i>495 Ritchie Hwy. Barranco Funeral Home Severna Park MD</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Ischemic Heart Disease</i> DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate interval between Onset and Death <i>1 month</i>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Hypothyroidism</i> <i>Senile Dementia</i> <i>Left hip fracture</i>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Tsu-Chun Lin</i>				29c. LICENSE NUMBER <i>D24756</i>		29d. DATE SIGNED (Month, Day, Year) <i>4-25-95</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Tsu-Chun Lin MD 377-B Gambrills Rd. Gambrills Md. 21045</i>							
31. DATE FILED (Month, Day, Year) <i>APR 27 1995</i> REGISTRAR'S SIGNATURE <i>Julia D. [Signature]</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13577

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) Nathanael S. Morehead				2. DATE OF DEATH MONTH April DAY 7, YEAR 1995		3. TIME OF DEATH 10:30 P.M.	
4. SOCIAL SECURITY NUMBER 241-18-7411		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 74 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) January 30, 1921	
8. BIRTHPLACE (State or Foreign Country) North Carolina				9. COUNTY OF DEATH Prince George's			
9a. FACILITY NAME (If not institution, give street and number) Bowie Medical Center				9b. CITY, TOWN OR LOCATION OF DEATH Bowie		9c. COUNTY OF DEATH Prince George's	
RESIDENCE OF DECEASED							
10a. STATE N. Carolina		10b. COUNTY Guilford		10c. CITY, TOWN OR LOCATION Greensboro		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 4903 Tamaron Drive				10f. ZIP CODE 27410		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+				16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Personnel Executive		16b. KIND OF BUSINESS/INDUSTRY Burlington Industries	
17. FATHER'S NAME (First, Middle, Last) Wheeler S. Morehead				18. MOTHER'S NAME (First, Middle, Maiden Surname) Elizabeth Johnson			
19a. INFORMANT'S NAME (Type/Print) Glendia R. Hatton				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16203 Aveston Place Bowie, MD 20716			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Guilford Memorial Park 4/12		20c. LOCATION — City or Town, State Greensboro, N. Carolina			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Robert E. Evans Pres.				22. NAME AND ADDRESS OF FACILITY Evans Funeral Home, P.A. 16000 Annapolis Rd. Bowie, Maryland 20715			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Arteriosclerotic Cardiovascular disease</u> DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Augusto P. Rodriguez MD				29c. LICENSE NUMBER B217230		29d. DATE SIGNED (Month, Day, Year) April 8, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Augusto P. Rodriguez MD, 5009 Layburn Ct. Sp Md 2748							
31. DATE FILED (Month, Day, Year) APR 11 1995		32. REGISTRAR'S SIGNATURE John A. Davidson					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Amended #9c 4/11/95 ELM P.G. County

95 13578

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ANDRE DESHAWN MCKOY				2. DATE OF DEATH MONTH DAY YEAR APRIL 06 1995		3. TIME OF DEATH 3:28 A M	
4. SOCIAL SECURITY NUMBER 579-80-8622		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 17 YRS.		7. DATE OF BIRTH (Month, Day, Year) 05-31-77	
8a. FACILITY NAME (If not institution, give street and number) PRINCE GEORGES HOSPITAL				8b. CITY, TOWN OR LOCATION OF DEATH CHEVERLY		8c. COUNTY OF DEATH PRINCE GEORGES	
RESIDENCE OF DECEDENT							
10a. STATE District of Columbia		10b. COUNTY Washington		10c. CITY, TOWN OR LOCATION Washington		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 4213 Brooks Street N.E. #203				10f. ZIP CODE 20019		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Student		16b. KIND OF BUSINESS/INDUSTRY N/A			
17. FATHER'S NAME (First, Middle, Last) William T. Brooks, Jr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Patricia McKoy			
19a. INFORMANT'S NAME (Type/Print) Patricia A. McKoy				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) #203 4213 Brooks Street N.E., Washington, D.C.			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Harmony Mem. Park Ceme. 4/11/95 Landover, Md.		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John T. Stewart, III</i>				22. NAME AND ADDRESS OF FACILITY STEWART FUNERAL HOME 4001 Benning Rd. N.E., Wash. D.C.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Gunshot Wound of Chest DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 5 <input type="checkbox"/> Could not be determined 4 <input checked="" type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 4/6/95		28b. TIME OF INJURY 247 M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED subject shot		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) building		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 567 Ritchie Rd Capitol Heights, Md	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dennis J. Chute MD</i>				29c. LICENSE NUMBER O.C.M.E		29d. DATE SIGNED (Month, Day, Year) APRIL 06, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dennis J. Chute, M.D. 111 N. PENN STREET. BALTIMORE, MARYLAND							
31. DATE FILED (Month, Day, Year) APR 11 1995				32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13579

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JOHNNIE MITCHELL				2. DATE OF DEATH MONTH DAY YEAR APRIL 10, 1995		3. TIME OF DEATH 7:35 P M	
4. SOCIAL SECURITY NUMBER 249 24 3952		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		8. AGE (In yrs. last birthday) 76 YRS.		7. DATE OF BIRTH (Month, Day, Year) OCT. 16, 1918	
9a. FACILITY NAME (If not institution, give street and number) REGENCY NSG AND REHAB CENTER				9b. CITY, TOWN OR LOCATION OF DEATH FORESTVILLE		9c. COUNTY OF DEATH PRINCE GEORGES	
10a. STATE MARYLAND				10b. COUNTY PRINCE GEORGES		10c. CITY, TOWN OR LOCATION OXON HILL	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER 1817 BRIERFIELD ROAD			
10f. ZIP CODE 20745				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Married <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6TH. College (1-4 or 5+) DOMESTIC		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) PRIVATE		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) HENRY LEWIS				18. MOTHER'S NAME (First, Middle, Maiden Surname) LIZA ANN MITCHELL LEWIS			
19a. INFORMANT'S NAME (Type/Print) MRS. VERA HAMER/DAUGHTER				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1817 BRIERFIELD ROAD, OXON HILL, M.D. 20745			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) NEW HOLLY		20c. LOCATION — City or Town, State 4/15 LITTLE ROCK, S.C.		22. NAME AND ADDRESS OF FACILITY E.M. DUDLEY FUNERAL HOME 3200 R.I. AVE. MT. RAINIER, MD 20712	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. RESPIRATORY FAILURE DUE TO (OR AS A CONSEQUENCE OF): END STAGE METASTATIC PROSTATE CARCINOMA DUE TO (OR AS A CONSEQUENCE OF): CACHEXIA DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death ONE DAY			
23. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DYSPHAGIA HE WAS DNR				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO N/A	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER D-34525		29d. DATE SIGNED (Month, Day, Year) APRIL 12, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) S.J. RAO, MD-4000 MITCHELLVILLE ROAD, SUITE 220, BOWIE, MD. 20716							
31. DATE FILED (Month, Day, Year) APR 13 1995				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) KAMIL MUSTAFA MOHAMED-NOUR				2. DATE OF DEATH MONTH DAY YEAR APRIL 12 95		3. TIME OF DEATH 4:00P M	
4. SOCIAL SECURITY NUMBER 231-51-4367		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 36 YRS.		7. DATE OF BIRTH (Month, Day, Year) Nov 29, 1959	
8. BIRTHPLACE (State or Foreign Country) SUDAN		9a. FACILITY NAME (If not institution, give street and number) 7200 MARTIN LUTHER KING HWY		9b. CITY, TOWN OR LOCATION OF DEATH LANDOVER		9c. COUNTY OF DEATH PRINCE GEORGES	
10a. STATE Maryland				10b. COUNTY Prince George		10c. CITY, TOWN OR LOCATION District Heights	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 2735 Lorrinq Dr. #103		10f. ZIP CODE 20747	
10g. CITIZEN OF WHAT COUNTRY? USA				11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: Black		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 8+) 4	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Laundry Operator				16b. KIND OF BUSINESS/INDUSTRY Laundry		17. FATHER'S NAME (First, Middle, Last) Mustafa Nour	
18. MOTHER'S NAME (First, Middle, Maiden Surname) Kadamala Gassam				19a. INFORMANT'S NAME (Type/Print) Adil Salih		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14122 Autumn Dr, Centerville, Va 22020	
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Family Cemetery 4-20-95		20c. LOCATION — City or Town, State Madani, Sudan	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Samuel Mateo</i>				22. NAME AND ADDRESS OF FACILITY 411 Kennedy St, N.W. Universal Mortuary Washington, D.C.		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. MULTIPLE INJURIES DUE TO (OR AS A CONSEQUENCE OF): Sequitentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? XX YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>				25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) AT SCENE	
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) 4/12/95		28b. TIME OF INJURY 1400 M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED DRIVER-AUTO-AUTO-COLLISION		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) ROADWAY		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 7200 MARTIN LUTHER KING HWY		29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John Davidson Randall</i>				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) APRIL 13/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DAVID R. FOWLER 111 PENN STREET, BALTIMORE, MARYLAND 21201							
31. DATE FILED (Month, Day, Year) APR 14 1995				32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

2

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

APR 14 1957

95-1983-033

95-095

ML

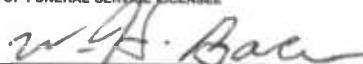
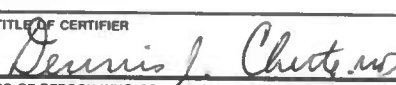

Amended # 1, P.G., GC, 4/12/95

Item # 23, Part I, 27, Per MEO, PG, GC, 4/20/95

95 13581

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JOSE				2. DATE OF DEATH MONTH APRIL DAY 07 YEAR 1995				3. TIME OF DEATH 12:29 P M	
4. SOCIAL SECURITY NUMBER 230-61-9001		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 28 YRS.		7. DATE OF BIRTH (Month, Day, Year) 10 11 66		8. BIRTHPLACE (State or Foreign Country) EL SALVADOR	
9a. FACILITY NAME (If not Institution, give street and number) PRINCE GEORGES HOSPITAL CENTER				9b. CITY, TOWN OR LOCATION OF DEATH CHEVERLY				9c. COUNTY OF DEATH PRINCE GEORGES	
10a. STATE VA		10b. COUNTY VIENNA		10c. CITY, TOWN OR LOCATION VIENNA		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER 118 PATRICK STREET				10f. ZIP CODE 22180		10g. CITIZEN OF WHAT COUNTRY? EL SALVADOR			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR OATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: HISPANIC			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6TH		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) DISH WASHER		16b. KIND OF BUSINESS/INDUSTRY RESTAURANT					
17. FATHER'S NAME (First, Middle, Last) JOSE ALBERTO MEJIA				18. MOTHER'S NAME (First, Middle, Maiden Surname) MARIO ISABEL MENDEZ					
19a. INFORMANT'S NAME (Type/Print) VATIUIDAD M. MENDEZ				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 118 PATRICK STREET VIENNA VIRGINIA 22180					
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) FAMILY CEMETERY		OATE 4/18/95		20c. LOCATION — City or Town, State EL SALVADOR			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY W.H. BACON FUNERAL HOME INC. 3447 14TH STREET, N.W. WASH, D.C. 20010					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → PNEUMONITIS AND ENCEPHALITIS (TOXOPLASMOSIS) ACQUIRED IMMUNE DEFICIENCY SYNDROME Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO									
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) APRIL 08, 1995			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 111 PENN STREET, BALTIMORE, MARYLAND 21201									
31. DATE FILED (Month, Day, Year) APR 12 1995		32. REGISTRAR'S SIGNATURE 							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13582

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) CHARLIE H. MCCAIN				2. DATE OF DEATH MONTH APRIL DAY 3 YEAR 1995		3. TIME OF DEATH 9:00 P M	
4. SOCIAL SECURITY NUMBER 252-26-3291		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 74 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 15, 1920	
8. BIRTHPLACE (State or Foreign Country) South Carolina				9a. FACILITY NAME (If not institution, give street and number) Prince George's Hospital Center		9b. CITY, TOWN OR LOCATION OF DEATH Cheverly	
9c. COUNTY OF DEATH Prince George's				10a. STATE Maryland		10b. COUNTY Prince George's	
10c. CITY, TOWN OR LOCATION Capitol Heights				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:	
14. RACE — American Indian, Black, White, etc. Specify: Black				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Sargeant First Class	
16b. KIND OF BUSINESS/INDUSTRY U.S. Army (Retired)				17. FATHER'S NAME (First, Middle, Last) Charlie Robert McCain			
18. MOTHER'S NAME (First, Middle, Maiden Surname) Marylou Hammond				19a. INFORMANT'S NAME (Type/Print) Lillie Mae McCain (Wife)			
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 410 Larchmont Avenue Capitol Heights, Maryland 20743				20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			
20b. PLACE AND DATE OF DISPOSITION (Name of Facility, Street and Number or Rural Route Number, City or Town, State, Zip Code) Fort Lincoln Cemetery 4/8/95				20c. LOCATION — City or Town, State Brentwood, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>P. B. Taylor</i>				22. NAME AND ADDRESS OF FACILITY Rotlins Funeral Home, Inc. 4339 Hunt Place, N.E. Washington, D.C. 20019			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. cardiogenic shock DUE TO (OR AS A CONSEQUENCE OF): myocardial ischemia DUE TO (OR AS A CONSEQUENCE OF): sepsis DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death: 1 week 1 week 1 week							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John Davidson-Randall</i>				29c. LICENSE NUMBER 030318		29d. DATE SIGNED (Month, Day, Year) 4/4/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)							
31. DATE FILED (Month, Day, Year) APR 10 1995				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13583

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) DIANA LYNN MCCORMICK				2. DATE OF DEATH MONTH DAY YEAR April 16, 1995		3. TIME OF DEATH 10:00 A M	
4. SOCIAL SECURITY NUMBER 236-80-5042		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 44 YRS.		7. DATE OF BIRTH (Month, Day, Year) Dec 19, 1950	
8. BIRTHPLACE (State or Foreign Country) MD				9a. FACILITY NAME (If not institution, give street and number) MEMORIAL HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH CUMBERLAND	
9c. COUNTY OF DEATH ALLEGANY				10a. STATE MD		10b. COUNTY Allegany	
10c. CITY, TOWN OR LOCATION Little Orleans				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER Route 1 Box 8	
10f. ZIP CODE 21766				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home	
17. FATHER'S NAME (First, Middle, Last) Dale B. Sipes				18. MOTHER'S NAME (First, Middle, Maiden Surname) Helen Cozad			
19a. INFORMANT'S NAME (Type/Print) Dale B. Sipes				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) High Germany Road Little Orleans, MD 21766			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Martin Cemetery 04/19		20c. LOCATION — City or Town, State Little Orleans, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James F. Scarpelli</i>				22. NAME AND ADDRESS OF FACILITY Scarpelli Funeral Home Cumberland, MD 21502			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF): b. Coronary Artery Disease DUE TO (OR AS A CONSEQUENCE OF): c. Diabetes Mellitus DUE TO (OR AS A CONSEQUENCE OF): d. Scleroderma Approximate Interval Between Onset and Death 1 hour 2 years less than 20 years less than 5 years							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER D23371		29d. DATE SIGNED (Month, Day, Year) April 19, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. Zaman Johnson Heights Medical Building Cumberland MD 21502							
31. DATE FILED (Month, Day, Year) APR 20 1995				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Amended #4, 4/19/95, N.D.S., Allegany Co.

95 13584

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) DENNIS FRANKLIN MANSPEAKER				2. DATE OF DEATH MONTH APRIL DAY 17 YEAR 1995		3. TIME OF DEATH 05:05 A^M	
4. SOCIAL SECURITY NUMBER 165-24-5852		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		8. AGE (In yrs. last birthday) 71 YRS.		7. DATE OF BIRTH (Month, Day, Year) Mar 9, 1924	
9a. FACILITY NAME (If not institution, give street and number) SACRED HEART HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH CUMBERLAND				9c. COUNTY OF DEATH ALLEGANY	
10a. STATE MD				10b. COUNTY Allegany		10c. CITY, TOWN OR LOCATION Cumberland	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 11 Blackiston Avenue			
10f. ZIP CODE 21502				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Retired Printer		15b. KIND OF BUSINESS/INDUSTRY Newspaper			
17. FATHER'S NAME (First, Middle, Last) James Manspeaker				18. MOTHER'S NAME (First, Middle, Maiden Surname) Leona (Shinn)			
19a. INFORMANT'S NAME (Type/Print) Louise A. Manspeaker				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11 Blackiston Avenue; Cumberland, MD 21502			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) St. Pauls Un Ch of Christ 04/19		20c. LOCATION — City or Town, State Yellow Creek, PA			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE James F. Scarpelli				22. NAME AND ADDRESS OF FACILITY Scarpelli Funeral Home Cumberland, MD 21502			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → metastatic colon cancer DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate interval Between Onset and Death 6 weeks							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Robert Orfino, M.D.				29c. LICENSE NUMBER 034846		29d. DATE SIGNED (Month, Day, Year) APRIL 17, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. ROBERT ORFINO, M.D., 902 SETON DRIVE, CUMBERLAND, MD 21502							
31. DATE FILED (Month, Day, Year) APR 19 1995				32. REGISTRAR'S SIGNATURE John H. Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13585

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Margaret W. Mayne</i>				2. DATE OF DEATH MONTH DAY YEAR <i>4 18 95</i>		3. TIME OF DEATH <i>0608hr</i>	
4. SOCIAL SECURITY NUMBER <i>217-50-1703</i>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>88</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>June 10, 1906</i>	
8. BIRTHPLACE (State or Foreign Country) <i>Maryland</i>				9a. FACILITY NAME (If not institution, give street and number) <i>Montgomery General Hospital</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>Olney</i>	
9c. COUNTY OF DEATH <i>Montgomery</i>				10a. STATE <i>Maryland</i>		10b. COUNTY <i>Carroll</i>	
10c. CITY, TOWN OR LOCATION <i>Mt. Airy</i>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER <i>201 Watersville Road</i>	
10f. ZIP CODE <i>21771</i>				10g. CITIZEN OF WHAT COUNTRY? <i>United States</i>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>4</i> College (1-4 or 5+) <i>College</i>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Homemaker</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Own Home</i>	
17. FATHER'S NAME (First, Middle, Last) <i>John Poole</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Clara Grimes</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Dorothy V. Hall</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>201 Watersville Road, Mt. Airy, Md. 21771</i>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Jennings Chapel Cemetery 4/21/95</i>		20c. LOCATION — City or Town, State <i>Florence, Md.</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Olin L. Molesworth</i>				22. NAME AND ADDRESS OF FACILITY <i>Olin L. Molesworth, P.A. 26401 Ridge Rd., Damascus, Md. 20872</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Respiratory failure</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>Abdominal infection & Renal failure</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i>Duodenal perforation</i> DUE TO (OR AS A CONSEQUENCE OF): d. Approximate interval Between Onset and Death <i>2 day</i>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Arthur F. Woodward, Jr.</i>				29c. LICENSE NUMBER <i>024190</i>		29d. DATE SIGNED (Month, Day, Year) <i>4/18/95</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Arthur F. Woodward, Jr. #205 3416 Olmewood Ct Olney Rd 20832</i>							
31. DATE FILED (Month, Day, Year) <i>APR 19 1995</i>				32. REGISTRAR'S SIGNATURE <i>John Andrew Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. The first part of the report deals with the general situation of the country and the progress of the work during the year. It also mentions the results of the various expeditions and the collections made.

2. The second part of the report deals with the results of the various expeditions and the collections made. It mentions the names of the various expeditions and the names of the collectors.

3. The third part of the report deals with the results of the various expeditions and the collections made. It mentions the names of the various expeditions and the names of the collectors.

4. The fourth part of the report deals with the results of the various expeditions and the collections made. It mentions the names of the various expeditions and the names of the collectors.

5. The fifth part of the report deals with the results of the various expeditions and the collections made. It mentions the names of the various expeditions and the names of the collectors.

95 13586

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Lael C. Miller				2. DATE OF DEATH MONTH DAY YEAR April 26 1995		3. TIME OF DEATH 11:24 AM	
4. SOCIAL SECURITY NUMBER 276-20-4328		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 93 YRS.		7. DATE OF BIRTH (Month, Day, Year) April 8, 1902	
8. BIRTHPLACE (State or Foreign Country) Iowa				9a. FACILITY NAME (If not institution, give street and number) Lorien Nursing Home		9b. CITY, TOWN OR LOCATION OF DEATH Columbia	
9c. COUNTY OF DEATH Howard				10a. STATE Maryland		10b. COUNTY Howard	
10c. CITY, TOWN OR LOCATION Highland				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 6547 River Clyde Drive	
10f. ZIP CODE 20777				10g. CITIZEN OF WHAT COUNTRY? United States		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Teacher		16b. KIND OF BUSINESS/INDUSTRY Private School System	
17. FATHER'S NAME (First, Middle, Last) Albert F. Church				18. MOTHER'S NAME (First, Middle, Maiden Surname) Grace T. Thorne			
19a. INFORMANT'S NAME (Type/Print) Ms. Tecla Jaskulski				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6547 River Clyde Drive Highland, Maryland 20777			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Balt-Wash Crematory Apr 27		20c. LOCATION — City or Town, State Laurel, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Stanley M. Lewner				22. NAME AND ADDRESS OF FACILITY Harry H Witzke Funeral Home Inc 4112 Old Columbia Pike Ellicott City 21043			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pneumonia with Dehydration							
DUE TO (OR AS A CONSEQUENCE OF):							
b. Severe Dementia — Alzheimer's type							
DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER [Signature]				29c. LICENSE NUMBER D-34869		29d. DATE SIGNED (Month, Day, Year) 4-27-95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DIBAZU 11055 LITTLE PINE STREET PINEBLUFF COLUMBIA, MD 21044							
31. DATE FILED (Month, Day, Year) APR 27 1995				32. REGISTRAR'S SIGNATURE [Signature]			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

REV BUCHANAN

REV BUCHANAN

REV BUCHANAN

95 13587

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ROSALIE - - (MARSHALL) MARSHALL				2. DATE OF DEATH MONTH DAY YEAR APRIL 16, 1995		3. TIME OF DEATH 2340 M	
4. SOCIAL SECURITY NUMBER 215-20-4443		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 76 YRS.		7. DATE OF BIRTH (Month, Day, Year) Oct. 9, 1918	
9a. FACILITY NAME (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER		9b. CITY, TOWN OR LOCATION OF DEATH SALISBURY		9c. COUNTY OF DEATH WICOMICO			
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Somerset		10c. CITY, TOWN OR LOCATION Crisfield		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 27338 Cash Corner Road				10f. ZIP CODE 21817		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) Grade 8 College (1-4 or 5+) - - -		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Employee		16b. KIND OF BUSINESS/INDUSTRY Mrs. Paul's Kitchens			
17. FATHER'S NAME (First, Middle, Last) Ira Thomas				18. MOTHER'S NAME (First, Middle, Maiden Surname) Hilda Webster			
19a. INFORMANT'S NAME (Type/Print) Kenneth M. Marshall (Husband)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27338 Cash Corner Rd. - Crisfield, MD 21817			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Sunnyridge Memorial Park-4/19/95		DATE 4/19/95		20c. LOCATION — City or Town, State Crisfield, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Robert H. Bradshaw, Jr.				22. NAME AND ADDRESS OF FACILITY Bradshaw & Sons Funeral Home 306 W. Main St. - Crisfield, MD 21817			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. Acute Pulmonary Edema DUE TO (OR AS A CONSEQUENCE OF):					Approximate Interval Between Onset and Death 2 hrs.
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. Acute Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF):					10 hrs.
		c. Severe Coronary Artery Disease DUE TO (OR AS A CONSEQUENCE OF):					4 yrs.
		d.					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Mellitus Chronic Arthritis							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURRED			
		28i. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Benito Chan				29c. LICENSE NUMBER D-20050		29d. DATE SIGNED (Month, Day, Year) 4/16/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Benito Chan 5470 RIVERSIDE DR. SALISBURY, MD. 21801							
31. DATE FILED (Month, Day, Year) APR 18 1995		32. REGISTRAR'S SIGNATURE Julia Anderson-Randall					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13588

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JOSEPH ANTHONY MAZZUCCA				2. DATE OF DEATH MONTH DAY YEAR April 11, 1995		3. TIME OF DEATH 11:05 P M		
4. SOCIAL SECURITY NUMBER 111-18-7988		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 86 YRS.		7. DATE OF BIRTH (Month, Day, Year) Mar 9, 1909		
9a. FACILITY NAME (If not institution, give street and number) MEMORIAL HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH CUMBERLAND		9c. COUNTY OF DEATH ALLEGANY		
10a. STATE MD		10b. COUNTY Allegany		10c. CITY, TOWN OR LOCATION Cumberland		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		
10e. STREET AND NUMBER 12106 Old Cash Valley RD				10f. ZIP CODE 21502		10g. CITIZEN OF WHAT COUNTRY? USA		
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Ret. Civil Engineer		16b. KIND OF BUSINESS/INDUSTRY Lockwood Green				
17. FATHER'S NAME (First, Middle, Last) Ralph Mazzucca				18. MOTHER'S NAME (First, Middle, Maiden Surname) nmn				
19a. INFORMANT'S NAME (Type/Print) Jean Mazzucca				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12106 Old Cash Valley Road: Cumberland, MD 21502				
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gate of Heaven Cemetery		20c. LOCATION — City or Town, State 04/15 Valhalla, NY		20d. DATE		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James F. Scarpelli</i>				22. NAME AND ADDRESS OF FACILITY Scarpelli Funeral Home for McMahon Funeral Home Cumberland, MD 21502				
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Ischemic cardiomyopathy DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. Coronary artery disease DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate interval Between Onset and Death 3 years unknown	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. MANNER OF DEATH 4 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 3 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 2 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
29b. SIGNATURE AND TITLE OF CERTIFIER <i>H.C. Merrick</i>				29c. LICENSE NUMBER D 28910		29d. DATE SIGNED (Month, Day, Year) April 12/94		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. H.C. Merrick, Memorial Hospital Medical Bldg., Cumberland, MD 21502								
31. DATE FILED (Month, Day, Year) APR 13 1995				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>				

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13589

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JACK KENNEDY MURPHY SR.				2. DATE OF DEATH MONTH APRIL DAY 6 YEAR 1995		3. TIME OF DEATH 0719 P M	
4. SOCIAL SECURITY NUMBER 218-12-5090		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 71 YRS.	7. DATE OF BIRTH (Month, Day, Year) May 29, 1923	8. BIRTHPLACE (State or Foreign Country) WV		
9a. FACILITY NAME (If not institution, give street and number) 217 INDUSTRIAL BLVD W				9b. CITY, TOWN OR LOCATION OF DEATH CUMBERLAND, MD.		9c. COUNTY OF DEATH ALLEGANY	
10a. STATE MD				10b. COUNTY Allegany		10c. CITY, TOWN OR LOCATION Cumberland	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER 217 Industrial Blvd W		10f. ZIP CODE 21502	
10g. CITIZEN OF WHAT COUNTRY? USA				11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: white			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College				16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Retired Brakeman		17. KIND OF BUSINESS/INDUSTRY Railroad	
17. FATHER'S NAME (First, Middle, Last) James R. Murphy, Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Virginia B. (Files)			
19a. INFORMANT'S NAME (Type/Print) Dorothy I. Murphy				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 217 Industrial Blvd W; Cumberland, MD 21502			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Restlawn Memorial Gardens 04/10		20c. LOCATION — City or Town, State LaVale, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James F. Scarpelli</i>				22. NAME AND ADDRESS OF FACILITY Scarpelli Funeral Home Cumberland, MD 21502			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Coronary Artery Disease DUE TO (OR AS A CONSEQUENCE OF): b. Anoxic Encephalopathy DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death 6 years 4 years							Approximate Interval Between Onset and Death 6 years 4 years
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) March 6, 1995		28b. TIME OF INJURY 9:00 AM		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED fell during election		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) home		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 217 Industrial Blvd W Cumberland, MD			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>J. Poonai</i>				29c. LICENSE NUMBER D36766		29d. DATE SIGNED (Month, Day, Year) April 5, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. VIK POONAI 955 FREDERICK STREET CUMBERLAND, MD. 21502							
31. DATE FILED (Month, Day, Year) APR 13 1995				32. REGISTRAR'S SIGNATURE <i>John A. Kunkel</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13590

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Jessie Mae Nisson				2. DATE OF DEATH MONTH 04 DAY 21 YEAR 95		3. TIME OF DEATH 11:15 p.m.	
4. SOCIAL SECURITY NUMBER 214-48-7810		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 84 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) April 7, 1911	
8. BIRTHPLACE (State or Foreign Country) N. Carolina				9a. FACILITY NAME (If not institution, give street and number) Pleasant Living Convalescent Center		9b. CITY, TOWN OR LOCATION OF DEATH Edgewater	
9c. COUNTY OF DEATH Anne Arundel				10a. STATE MD		10b. COUNTY Anne Arundel	
10c. CITY, TOWN OR LOCATION Churchton				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 5604 Carroll Street	
10f. ZIP CODE 20733				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+) College				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Bakery operator		16b. KIND OF BUSINESS/INDUSTRY food service	
17. FATHER'S NAME (First, Middle, Last) Luraco York				18. MOTHER'S NAME (First, Middle, Maiden Surname) Alice Henrietta Mullis			
19a. INFORMANT'S NAME (Type/Print) Alma W. Nisson				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) same as # 10 above			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Macedonia Meth. Cemet. 4/26/95		20c. LOCATION — City or Town, State Harmony, NC	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>William R. H...</i>				22. NAME AND ADDRESS OF FACILITY Rausch Funeral Home, P.A., Owings, MD			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Lung Cancer DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. DESCRIBE HOW INJURY OCCURRED No injury			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Charles H. Wirth</i>				29c. LICENSE NUMBER D 12 512		29d. DATE SIGNED (Month, Day, Year) 4/22/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Charles H. Wirth, MD, 4837 Solomons Island Rd, Lothian 20711							
31. DATE FILED (Month, Day, Year) APR 25 1995				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13591

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) HILDA CHANNELL NEAL				2. DATE OF DEATH MONTH DAY YEAR April 23, 1995		3. TIME OF DEATH 8:20 A.	
4. SOCIAL SECURITY NUMBER 213-14-2637		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 73 YRS.		7. DATE OF BIRTH (Month, Day, Year) 1/10/1922	
8a. FACILITY NAME (If not institution, give street and number) Stella Maris Hospice				8b. CITY, TOWN OR LOCATION OF DEATH Towson		8c. COUNTY OF DEATH Baltimore	
10a. STATE Maryland		10b. COUNTY Harford		10c. CITY, TOWN OR LOCATION Street		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 3518 Prospect Road				10f. ZIP CODE 21154		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) Unknown		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own home			
17. FATHER'S NAME (First, Middle, Last) Hillen Holloway				18. MOTHER'S NAME (First, Middle, Maiden Surname) Margie McCleary			
19a. INFORMANT'S NAME (Type/Print) Donna C. Snodgrass				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3518 Prospect Road Street, MD 21154			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Centre Cemetery 4/26		20c. LOCATION — City or Town, State New Park, PA			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Jeffrey P. Lovelady</i>				22. NAME AND ADDRESS OF FACILITY Harkins Funeral Home, Inc. Delta, PA			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Multiple Sclerosis DUE TO (OR AS A CONSEQUENCE OF): Approximate interval Between Onset and Death 24 years Sequently ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Hospice					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Kendall R Faulkner</i>				29c. LICENSE NUMBER DA5643		29d. DATE SIGNED (Month, Day, Year) 4/23/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. KENDALL FAULKNER 2300 DULANEY VALLEY RD., TOWSON, MD 21204							
31. DATE FILED (Month, Day, Year) APR 26 1995		32. REGISTRAR'S SIGNATURE <i>John Andrew Radt</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13592

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Adams J Nelson				2. DATE OF DEATH MONTH April DAY 3 YEAR 1995				3. TIME OF DEATH 6:33 P M	
4. SOCIAL SECURITY NUMBER 253-24-7135		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 76 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS. HOURS 0 MIN. 0	
7. DATE OF BIRTH (Month, Day, Year) April 30 1918				8. BIRTHPLACE (State or Foreign Country) Norman Park Florida					
9a. FACILITY NAME (If not institution, give street and number) Washington Adventist Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Takoma Park, Md				9c. COUNTY OF DEATH Montgomery	
10a. STATE Md.		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Adelphi				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 1801 Metzertott Rd.				10f. ZIP CODE 20783		10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Secret Service				16b. KIND OF BUSINESS/INDUSTRY Government	
17. FATHER'S NAME (First, Middle, Last) John Henry Nelson				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Harris					
19a. INFORMANT'S NAME (Type/Print) Jamil Rasheed				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3921 Clark St. Capital Heights, Md. 20743					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Md. Veterans Cem. 4-11-95				20c. LOCATION — City or Town, State Cheltenham, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Sharon Johnson-Salley</i>				22. NAME AND ADDRESS OF FACILITY Capitol Mortuary 1425 Maryland Ave., NE Wash., DC					
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Acute myocardial infarction Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): Underlying Coronary Artery Disease b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death 1 hr 5 hr	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetic mellitus								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Myron L. Lenkin MD</i>				29c. LICENSE NUMBER 006674		29d. DATE SIGNED (Month, Day, Year) April 7 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MYRON L. LENKIN MD				2309 SHOREFIELD ROAD WHEATON MD. 20902					
31. DATE FILED (Month, Day, Year) APR 11 1995		32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13593

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>William Roy Newman</i>				2. DATE OF DEATH MONTH <i>April</i> DAY <i>6</i> YEAR <i>1995</i>		3. TIME OF DEATH <i>10:37P</i> M	
4. SOCIAL SECURITY NUMBER <i>579-40-0082</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>65</i> YRS.		7. DATE OF BIRTH MONTH <i>May</i> DAY <i>28</i> YEAR <i>1929</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Doctor's Hospital</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Lanham</i>		9c. COUNTY OF DEATH <i>Prince George's</i>	
10a. STATE <i>Maryland</i>		10b. COUNTY <i>Prince George's</i>		10c. CITY, TOWN OR LOCATION <i>Bowie</i>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <i>4501 Lottsford Vista Road</i>				10f. ZIP CODE <i>20720</i>		10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>Black</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <i>12th grade</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Landscaper</i>		16b. KIND OF BUSINESS/INDUSTRY <i>William G. Burton (Retired)</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Leo Thompson</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Mary Newman</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Mrs. Helen Newman (Wife)</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>4501 Lottsford Vista Road Bowie, Maryland 20720</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of Resurrection Cemetery		DATE <i>4/10/95</i>		20c. LOCATION — City or Town, State <i>Clinton, Maryland</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James C. Anderson</i>				22. NAME AND ADDRESS OF FACILITY <i>Rothmans Funeral Home, Inc. 4339 Hunt Place, N.E. Washington, D.C. 20019</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Intermittent cardiovascular disease</i> DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate interval Between Onset and Death <i>years</i>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Augusto P. Rodriguez MD</i>				29c. LICENSE NUMBER <i>B 21230</i>		29d. DATE SIGNED (Month, Day, Year) <i>April 7, 1995</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) <i>Augusto P. Rodriguez MD, 5009 Layman Rd. - Cp Jm. Md 20748</i>							
31. DATE FILED (Month, Day, Year) <i>APR 10 1995</i>				32. REGISTRAR'S SIGNATURE <i>John A. Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 5 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) DELANEY L. OLIVER, JR.				2. DATE OF DEATH MONTH DAY YEAR April 7, 1995		3. TIME OF DEATH 6:09 P. M.	
4. SOCIAL SECURITY NUMBER 421-24-8800		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 71 YRS.		7. DATE OF BIRTH (Month, Day, Year) Jan 21, 1924	
9a. FACILITY NAME (If not institution, give street and number) WASHINGTON ADVENTIST HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH TAKOMA PARK		9c. COUNTY OF DEATH MONTGOMERY	
10a. STATE MARYLAND				10b. COUNTY PRINCE GEORGES		10c. CITY, TOWN OR LOCATION FT. WASHINGTON	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
10e. STREET AND NUMBER 12021 LIVINGSTON ROAD				10f. ZIP CODE 20744		10g. CITIZEN OF WHAT COUNTRY? UNITED STATES	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1942 - 1946		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No - If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE - American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) College (1-4 or 5+) 4				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SOCIAL WORKER		16b. KIND OF BUSINESS/INDUSTRY NEW Y ORK CITY GOVERNMENT	
17. FATHER'S NAME (First, Middle, Last) DELANEY OLIVER, SR.				18. MOTHER'S NAME (First, Middle, Maiden Surname) VIOLA			
19a. INFORMANT'S NAME (Type/Print) Charles Oliver DELANEY A. OLIVER, III				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4701 Lamont Court, Temple Hills, MD 20748 9008 LITTLE STONE DRIVE, FT. WASHINGTON, MD 20744			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) QUANTICO NATIONAL CEMETERY 4/13		20c. LOCATION - City or Town, State TRIANGLE, VIRGINIA			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Alay S Pope Jr.</i> M859				22. NAME AND ADDRESS OF FACILITY ALEXANDER S. POPE FUNERAL HOMES 5538 MARLBORO PIKE, FORESTVILLE, MD 20747			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. END STAGE RENAL DISEASE DEPENDENT DIABETES MELLITUS DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Paul A. Devore</i>				29c. LICENSE NUMBER D01852		29d. DATE SIGNED (Month, Day, Year) April 7, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Paul A. Devore, M.D. 4203 QUEENSBURY ROAD, HYATTSVILLE, MD. 20781							
31. DATE FILED (Month, Day, Year) APR 12 1995				32. REGISTRAR'S SIGNATURE <i>John A. Devore</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13595

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Veronica Faye Oates</i>				2. DATE OF DEATH MONTH <i>4</i> DAY <i>1</i> YEAR <i>95</i>		3. TIME OF DEATH <i>4:30</i> p.m.	
4. SOCIAL SECURITY NUMBER <i>244-68-4058</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>53</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>3/4/42</i>	
8a. FACILITY NAME (If not institution, give street and number) <i>Holy Cross Hospital</i>				8b. CITY, TOWN OR LOCATION OF DEATH <i>Silver Spring</i>		8c. COUNTY OF DEATH <i>Montgomery</i>	
9a. STATE <i>Maryland</i>		9b. COUNTY <i>Prince George's County</i>		9c. CITY, TOWN OR LOCATION <i>Oxon Hill</i>		9d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10a. STREET AND NUMBER <i>1405 Southern Avenue #P3</i>				10f. ZIP CODE <i>20745</i>		10g. CITIZEN OF WHAT COUNTRY? <i>United States of America</i>	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>Black</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i></i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Receptionist</i>		16b. KIND OF BUSINESS/INDUSTRY <i>National Institute of Health</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Willie Lee Oates</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Eula Mae Pegues</i>			
19a. INFORMANT'S NAME (Type/Print) <i>William Oates</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1910 Clairemont Circle, Wilson, North Carolina</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Winstead Cemetery</i>		DATE <i>4/18/95</i>		20c. LOCATION — City or Town, State <i>Nash County, North Carolina</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Edward A. Carson</i> #M00690				22. NAME AND ADDRESS OF FACILITY <i>Edwards Funeral Home</i> <i>805 East Nash Street, Wilson, North Carolina 27893</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cardiorespiratory failure</i> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>Depressed Mental Status</i> <i>Sepsis</i> <i>Breast carcinoma</i>							Approximate interval between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Renal failure</i>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							25. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>A. S. Quinn M.D.</i>				29c. LICENSE NUMBER <i>D43626</i>		29d. DATE SIGNED (Month, Day, Year) <i>4/13/95</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>ANNE'S QUINN, KAISER PERMANENTE, 6104 Old Branch Ave, Temple Hills, MD 20748</i>							
31. DATE FILED (Month, Day, Year) <i>APR 18 1995</i>				32. REGISTRAR'S SIGNATURE <i>John D. Walker-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13596

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) WILLIAM O'NEAL				2. DATE OF DEATH MONTH April DAY 12 YEAR 1995		3. TIME OF DEATH 4:20 A M	
4. SOCIAL SECURITY NUMBER 577-66-2997		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 44 YRS.		7. DATE OF BIRTH (Month, Day, Year) 02/19/51	
8. BIRTHPLACE (State or Foreign Country) ALABAMA				9. COUNTY OF DEATH MONTGOMERY			
9a. FACILITY NAME (If not institution, give street and number) HOLY CROSS HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH SILVER SPRING		9c. COUNTY OF DEATH MONTGOMERY	
10a. STATE NA				10b. COUNTY NA		10c. CITY, TOWN OR LOCATION WASHINGTON, D.C.	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER 2107 SHIPLEY TERRACE #203		10f. ZIP CODE 20020	
10g. CITIZEN OF WHAT COUNTRY? United States				11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: BLACK			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) MANAGER		16b. KIND OF BUSINESS/INDUSTRY RETAIL	
17. FATHER'S NAME (First, Middle, Last) WILLIAM O'NEAL				18. MOTHER'S NAME (First, Middle, Maiden Surname) CATHERINE THOMAS			
19a. INFORMANT'S NAME (Type/Print) HATTIE LAWSON (Aunt)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9705 Harace Harding Expressway #17J Corona, NY 11368			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) METROPOLITAN CREMATORIUM 4/14		20c. LOCATION — City or Town, State ALEXANDRIA, VIRGINIA	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Alex S. Pope Jr.</i> M859				22. NAME AND ADDRESS OF FACILITY ALEXANDER S. POPE FUNERAL HOMES 5538 MARLBORO PIKE, FORESTVILLE, MD 20747			
23. PART I. Enter the diseases, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Systemic Inflammatory Response Syndrome DUE TO (OR AS A CONSEQUENCE OF): b. Necrotizing myofasciitis DUE TO (OR AS A CONSEQUENCE OF): c. Acquired Immune Deficiency Syndrome DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death 12 hours							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Lee Edward Schwab, MD</i>				29c. LICENSE NUMBER D22990		29d. DATE SIGNED (Month, Day, Year) 4/12/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Lee Edward Schwab, MD, Holy Cross Hospital, Silver Spring, Md							
31. DATE FILED (Month, Day, Year) APR 14 1995				32. REGISTRAR'S SIGNATURE <i>Julia Davidson Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13597

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) EDWARD J. O'Hearn				2. DATE OF DEATH MONTH April DAY 17, YEAR 1995		3. TIME OF DEATH 6:05 A. M.	
4. SOCIAL SECURITY NUMBER 191-28-6026		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 61 YRS.		7. DATE OF BIRTH (Month, Day, Year) April 7, 1934	
8. BIRTHPLACE (State or Foreign Country) Pennsylvania		9a. FACILITY NAME (If not institution, give street and number) 5203 Fairgreene Way		9b. CITY, TOWN OR LOCATION OF DEATH Ijamsville		9c. COUNTY OF DEATH Frederick	
10a. STATE Maryland				10b. COUNTY Frederick		10c. CITY, TOWN OR LOCATION Ijamsville	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER 5203 Fairgreene Way			
10f. ZIP CODE 21754				10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE YEAR OR DATES Korean		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Personnel Officer		16b. KIND OF BUSINESS/INDUSTRY Government			
17. FATHER'S NAME (First, Middle, Last) Vincent P. O'Hearn				18. MOTHER'S NAME (First, Middle, Maiden Surname) Marion Scanlon			
19a. INFORMANT'S NAME (Type/Print) Leonice Watts O'Hearn				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5203 Fairgreene Way Ijamsville, MD 21754			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) St. Josephs Cemetery 4/20/95		20c. LOCATION — City or Town, State Fountain Springs, PA			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James R. Stuffer</i>				22. NAME AND ADDRESS OF FACILITY Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike Frederick, MD 21702			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Cancer metastatic to colon</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. [Signature]</i>				29c. LICENSE NUMBER D07186		29d. DATE SIGNED (Month, Day, Year) 4/18/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 814 Toll House Ave Frederick, MD 21701							
31. DATE FILED (Month, Day, Year) APR 19 1995				32. REGISTRAR'S SIGNATURE <i>John [Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.


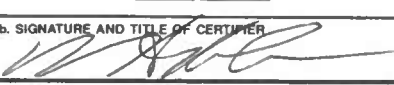
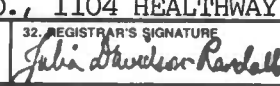
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13598

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last) GERTRUDE C. Phillips				2. DATE OF DEATH MONTH April DAY 11 YEAR 1995		3. TIME OF DEATH 12:42 P M	
4. SOCIAL SECURITY NUMBER 212-01-5507		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 97 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) 2-14-1898	
9a. FACILITY NAME (If not institution, give street and number) SALISBURY NURSING & REHAB CENTER				9b. CITY, TOWN OR LOCATION OF DEATH SALISBURY, MD.		9c. COUNTY OF DEATH WICOMICO	
10a. STATE MD.		10b. COUNTY WICOMICO		10c. CITY, TOWN OR LOCATION SALISBURY		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 608 PINE BLUFF RD.				10f. ZIP CODE 21801		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) NURSE		16b. KIND OF BUSINESS/INDUSTRY HOSPITAL			
17. FATHER'S NAME (First, Middle, Last) WILLIAM LEONARD CLARK				18. MOTHER'S NAME (First, Middle, Maiden Surname) MAMIE A. HORNBERGER			
19a. INFORMANT'S NAME (Type/Print) DICK CLARK				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 608 PINE BLUFF RD. SALISBURY, MD. 21801			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) ROCK SPRING CH. CEM 4-14		20c. LOCATION — City or Town, State FOREST HILL, MD.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY BOUNDS FUNERAL HOME, SALISBURY, MD.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pneumonia DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate interval Between Onset and Death deep
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D29349		29d. DATE SIGNED (Month, Day, Year) 4/14/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) WILLIAM ROBINS, M.D., 1104 HEALTHWAY DR., SALISBURY, Md. 21801							
31. DATE FILED (Month, Day, Year) APR 13 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL DR. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13599

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) WILLIAM THOMAS PARKER				2. DATE OF DEATH MONTH April DAY 14 YEAR 1995		3. TIME OF DEATH 1:20 A M	
4. SOCIAL SECURITY NUMBER 228-18-2149		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 69 YRS.		7. DATE OF BIRTH (Month, Day, Year) March 3, 1926	
8. BIRTHPLACE (State or Foreign Country) Virginia		9a. FACILITY NAME (If not institution, give street and number) 504 Cleveland Ave.		9b. CITY, TOWN OR LOCATION OF DEATH Salisbury		9c. COUNTY OF DEATH Wicomico	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Wicomico		10c. CITY, TOWN OR LOCATION Salisbury		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 504 Cleveland Ave.		10f. ZIP CODE 21801		10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES Merchant Marines		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yee or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) 10		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Plant manager		15b. KIND OF BUSINESS/INDUSTRY Ice Cream			
17. FATHER'S NAME (First, Middle, Last) William Thomas Parker				18. MOTHER'S NAME (First, Middle, Maiden Surname) Marie Paulson			
19a. INFORMANT'S NAME (Type/Print) Margaret M. Parker				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 504 Cleveland Ave., Salisbury, MD 21801			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Wicomico Memorial Park		DATE 4/17		20c. LOCATION — City or Town, State Salisbury, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>WR Hallen</i>				22. NAME AND ADDRESS OF FACILITY Holloway Funeral Home 501 Snow Hill Rd., Salisbury, MD 21801			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. METASTATIC ACINIC CELL CANCER DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death 2 YRS.
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PULMONARY EMBOLI							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Robert Allen, M.D.</i>				29c. LICENSE NUMBER D29168		29d. DATE SIGNED (Month, Day, Year) 4/18/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 560 Riverside Dr. Salisbury, Md. 21801							
31. DATE FILED (Month, Day, Year) APR 19 1995		32. REGISTRAR'S SIGNATURE <i>John Andrew Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13600

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Robert Lee Parks				2. DATE OF DEATH MONTH DAY YEAR April 15 1995				3. TIME OF DEATH 7:15 P.M.			
4. SOCIAL SECURITY NUMBER 243-18-4103				5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 73 YRS.		7. DATE OF BIRTH (Month, Day, Year) April 17 1921		8. BIRTHPLACE (State or Foreign Country) North Carolina	
9a. FACILITY NAME (If not institution, give street and number) 112 Oak St						9b. CITY, TOWN OR LOCATION OF DEATH Fruitland				9c. COUNTY OF DEATH Wicomico	
10a. STATE MD		10b. COUNTY Wicomico		10c. CITY, TOWN OR LOCATION Fruitland				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER 112 Oak St				10f. ZIP CODE 21826				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: Black			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Carpenter				16b. KIND OF BUSINESS/INDUSTRY Self-Employed			
17. FATHER'S NAME (First, Middle, Last) Arthur Parks						18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Welch					
19a. INFORMANT'S NAME (Type/Print) Ineill Parks						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 112 Oak St Fruitland, MD 21826					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Springhill Memory Gardens Hebron				20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Calvin L. Williams				22. NAME AND ADDRESS OF FACILITY 270 Fredhillon Pass CALVIN L. Williams Baltimore, MD 21229 F.S.							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → metastatic Cancer DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. COPD										Approximate Interval Between Onset and Death	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				28. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER [Signature]				29c. LICENSE NUMBER DS1546		29d. DATE SIGNED (Month, Day, Year) 4/17/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Ignacio C. Dinardo M.D.											
31. DATE FILED (Month, Day, Year) APR 18 1995				32. REGISTRAR'S SIGNATURE John Davidson Hardell							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13601

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) Reba G. Pardoe				2. DATE OF DEATH April 25, 1995		3. TIME OF DEATH 550 A	
4. SOCIAL SECURITY NUMBER 215 26 2334		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (in yrs. last birthday) 80	7. DATE OF BIRTH July 13, 1914		8. BIRTHPLACE (State or Foreign) Maryland	
9a. FACILITY NAME (If not institution, give street and number) Solomons Nursing Center				9b. CITY, TOWN OR LOCATION OF DEATH Solomons		9c. COUNTY OF DEATH Calvert	
10a. STATE Maryland				10b. COUNTY Calvert		10c. CITY, TOWN OR LOCATION Lusby	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 12825 McCready Road		10f. ZIP CODE 20657	
10g. CITIZEN OF WHAT COUNTRY? United States				11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: white		15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) 11	
16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) clerk grocery Store				16b. KIND OF BUSINESS/INDUSTRY retail sales		17. FATHER'S NAME (First, Middle, Last) J. Frank Elliott	
18. MOTHER'S NAME (First, Middle, Maiden Surname) Hattie V. Horsmon				19a. INFORMANT'S NAME (Type/Print) Suzanne P. Cibulay		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12825 McCready Rd. P.O. Box 584 Lusby, Maryland 20657	
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Middleham Chapel Cemetery April 27, 1995		20c. LOCATION — City or Town, State Lusby Calvert Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Brower				22. NAME AND ADDRESS OF FACILITY Rausch Funeral Home P.A. 4405 Broomes Is. Rd. Port Republic Maryland 20676			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Organic brain syndrome DUE TO (OR AS A CONSEQUENCE OF): b. Diabetes DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Charles W. Bennett M.D.				29c. LICENSE NUMBER D25156		29d. DATE SIGNED (Month, Day, Year) April 25 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Charles W. Bennett, M.D. 11845 H.G. Trueman Rd. Lusby, Maryland							
31. DATE FILED (Month, Day, Year) APR 26 1995				32. REGISTRAR'S SIGNATURE John Davidson Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95-1990-005

blh

ITEMS: 23 PART I, 27, PER MEO FILM G-723 5/19/95 t.t

95 13602

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Donnell Hershell Parran				2. DATE OF DEATH MONTH DAY YEAR April 08 1995		3. TIME OF DEATH 0623 M	
4. SOCIAL SECURITY NUMBER 219-78-7649		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		8. AGE (In yrs. last birthday) 33 YRS.		7. DATE OF BIRTH (Month, Day, Year) Sept. 20, 1961	
9a. FACILITY NAME (If not institution, give street and number) Northwest Medical Center		9b. CITY, TOWN OR LOCATION OF DEATH Randalstown		9c. COUNTY OF DEATH Baltimore			
10a. STATE Maryland		10b. COUNTY		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 3701 Twin Lakes Court Apt. 201				10f. ZIP CODE 21244		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Laborer		16b. KIND OF BUSINESS/INDUSTRY Construction			
17. FATHER'S NAME (First, Middle, Last) Maurice Gudger				18. MOTHER'S NAME (First, Middle, Maiden Surname) Oveta Parran			
19a. INFORMANT'S NAME (Type/Print) Oveta Watkins				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6813 Eilerson St. Clinton, MD 20735			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) St. Edmond UM Chr. Cem. 4/13/95		20c. LOCATION — City or Town, State Chesapeake Beach, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Spencer E. Sewell</i>				22. NAME AND ADDRESS OF FACILITY Sewell Funeral Home 1451 Dares Beach Rd. Prince Frederick, MD			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → CARDIAC ARRHYTHMIA DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Mark F. Goltz JR MD</i>				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) April 09 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Mark F. Goltz JR MD 111 Penn Street, Baltimore Maryland 21201							
31. DATE FILED (Month, Day, Year) APR 21 1995		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

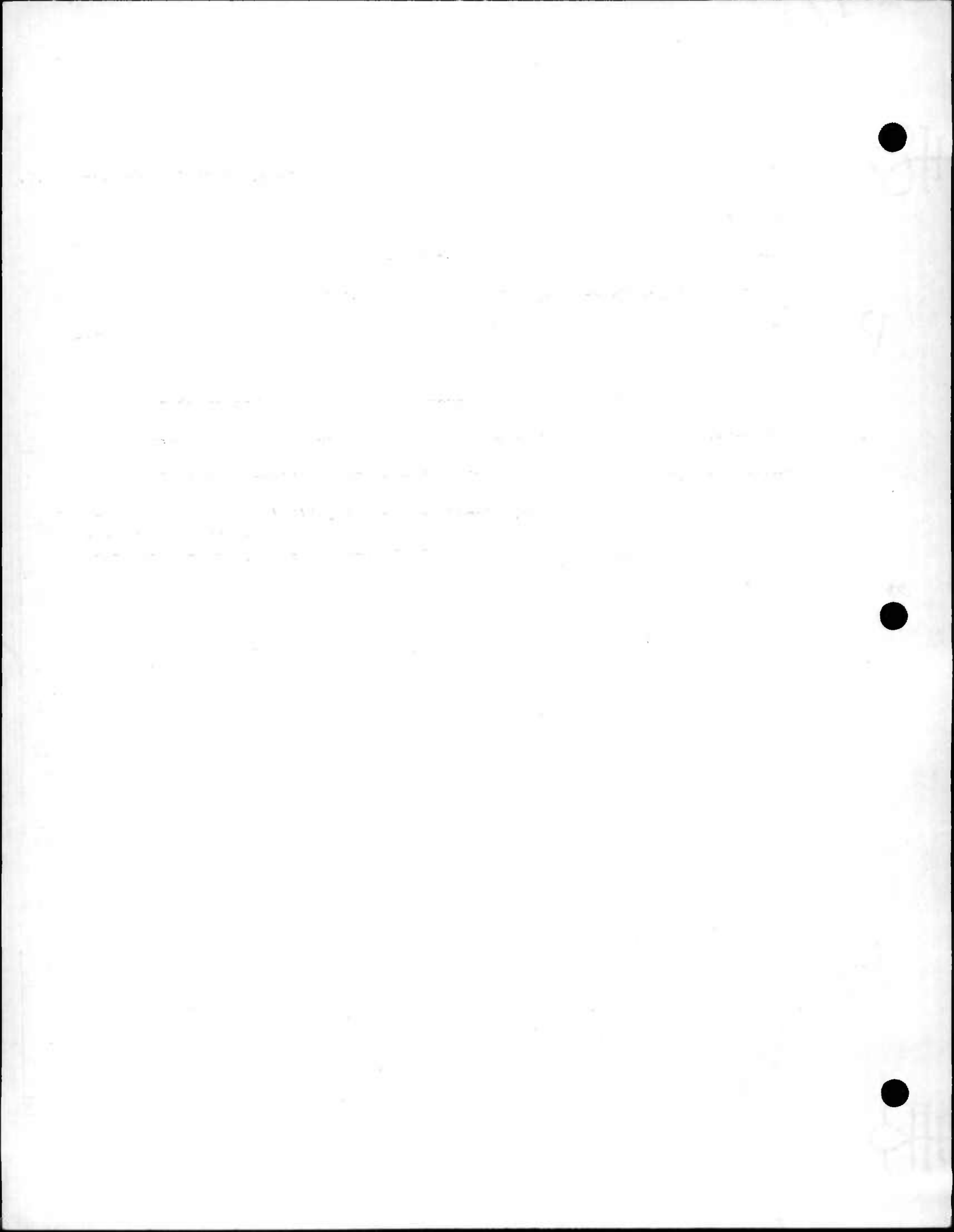
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 13603

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) <i>Walter PATTON, SR.</i>				2. DATE OF DEATH MONTH <i>APRIL</i> DAY <i>10</i> YEAR <i>1995</i>				3. TIME OF DEATH <i>2 P.</i>					
4. SOCIAL SECURITY NUMBER <i>248-46-5485</i>				5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (in yrs. last birthday) <i>60</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>Apr 26, 1934</i>		8. BIRTHPLACE (State or Foreign Country) <i>South Carolina</i>			
9a. FACILITY NAME (If not institution, give street and number) <i>3916 TRITON COURT</i>						9b. CITY, TOWN OR LOCATION OF DEATH <i>TEMPLE HILLS</i>				9c. COUNTY OF DEATH <i>PRINCE GEORGES</i>			
RESIDENCE OF DECEASED													
10a. STATE <i>Maryland</i>				10b. COUNTY <i>Prince Georges</i>				10c. CITY, TOWN OR LOCATION <i>Temple Hills</i>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <i>3916 TRITON COURT</i>						10f. ZIP CODE <i>20748</i>				10g. CITIZEN OF WHAT COUNTRY? <i>UNITED STATES</i>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <i>BLACK</i>	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i></i>				16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>CARPENTER</i>				16b. KIND OF BUSINESS/INDUSTRY <i>CONSTRUCTION</i>					
17. FATHER'S NAME (First, Middle, Last) <i>WALTER PATTON</i>						18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>ROSIE BANKS</i>							
19a. INFORMANT'S NAME (Type/Print) <i>SHIRLEY PATTON</i>						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>3916 TRITON COURT, TEMPLE HILLS, MD. 20748</i>							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>CEDAR HILL CEMETERY</i>				20c. DATE <i>4/14</i>		20d. LOCATION — City or Town, State <i>SUITLAND, MARYLAND</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Alex S. Pope Jr.</i>						22. NAME AND ADDRESS OF FACILITY <i>ALEXANDER S. POPE FUNERAL HOMES 5538 MARLBORO PIKE, FORESTVILLE, MD 20747</i>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Atherosclerotic Cardiovascular disease</i>													
DUE TO (OR AS A CONSEQUENCE OF):													
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST													
b. DUE TO (OR AS A CONSEQUENCE OF):													
c. DUE TO (OR AS A CONSEQUENCE OF):													
d. DUE TO (OR AS A CONSEQUENCE OF):													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Ethylism</i>													
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO													
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO													
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Augusto P. Rodriguez MD</i>						29c. LICENSE NUMBER <i>Q 21230</i>				29d. DATE SIGNED (Month, Day, Year) <i>April 10, 1995</i>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Augusto P. Rodriguez MD 5009 Rayburn Ct Gt Spc Md 20748</i>													
31. DATE FILED (Month, Day, Year) <i>APR 12 1995</i>				32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13604

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>MABLE H. PRICE</i>				2. DATE OF DEATH MONTH DAY YEAR <i>APRIL 7 1995</i>		3. TIME OF DEATH <i>21:09</i>	
4. SOCIAL SECURITY NUMBER <i>578-20-6221</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>80</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>9-5-1914</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Washington Adventist Hospital</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Montgomery County</i>		9c. COUNTY OF DEATH <i>Montgomery</i>	
10a. STATE <i>Md.</i>		10b. COUNTY <i>P.C.</i>		10c. CITY, TOWN OR LOCATION <i>Hyattsville Maryland</i>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <i>1117-Oakdale Dr. Hyattsville, Md.</i>				10f. ZIP CODE <i>20782</i>		10g. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: <i>Black</i>		14. RACE — American Indian, Black, White, etc. Specify: <i>Black</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>10th</i> College (1-4 or 5+) <i></i>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Nurse Aide</i>		15b. KIND OF BUSINESS/INDUSTRY <i>Hospital</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Robert Helms</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Merrie Coulden</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Mabel E. Thomas</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1117-Oakdale Dr. Hyattsville, Md. 20782</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Glenwood Cemetery 4/12 Washington, D.C.</i>		20c. LOCATION — City or Town, State <i>Washington, D.C.</i>		20d. DATE <i>4/12/95</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Laverne E. Montgomery #819</i>				22. NAME AND ADDRESS OF FACILITY <i>Montgomery Brothers F.H. 719-Kennedy St. N.W. Wash. D.C. 20011</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>ASPIRATION PNEUMONIA</i>							
DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
b. <i>BRAIN STEM STROKE</i>							
DUE TO (OR AS A CONSEQUENCE OF):							
c. <i>ATHEROSCLEROTIC HEART DISEASE</i>							
DUE TO (OR AS A CONSEQUENCE OF):							
d. <i></i>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>RENAL FAILURE SEPSIS</i>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <i>19971</i>		29d. DATE SIGNED (Month, Day, Year) <i>04/07/95</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>K. SUDHAKAR. 7610 CARROLL AVE #230, NAKOMA PARK MD 20912</i>							
31. DATE FILED (Month, Day, Year) <i>APR 11 1995</i>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Marvin A. Pennington</i>				2. DATE OF DEATH MONTH DAY YEAR <i>April 20, 1995</i>		3. TIME OF DEATH <i>5:20 a m</i>	
4. SOCIAL SECURITY NUMBER <i>217-10-5348</i>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>75</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>March 10, 1920</i>	
8. BIRTHPLACE (State or Foreign Country) <i>West Virginia</i>				9a. FACILITY NAME (If not institution, give street and number) <i>Frostburg Hospital</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>Frostburg</i>	
9c. COUNTY OF DEATH <i>Allegany</i>				10a. STATE <i>Maryland</i>		10b. COUNTY <i>Allegany</i>	
10c. CITY, TOWN OR LOCATION <i>Frostburg</i>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER <i>229 W. First Street</i>	
10f. ZIP CODE <i>21532</i>				10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <i>W.W.II</i>				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>0</i>			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Maintenance</i>				16b. KIND OF BUSINESS/INDUSTRY <i>Tire Manufacturing</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Payden B. Pennington</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Viola F. Lewis</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Mildred Pennington</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>229 W. First Street Frostburg, Maryland 21532</i>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Eckhart Cemetery April 22, 95</i>			
20c. LOCATION — City or Town, State <i>Eckhart, Maryland</i>				21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John R. Durst</i>			
22. NAME AND ADDRESS OF FACILITY <i>Durst Funeral Home 57 Frost Avenue Frostburg, Md. 21532</i>				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <i>Ca of the lung, metastasis to pleura and liver</i>			
IMMEDIATE CAUSE (Final disease or condition resulting in death) →				Approximate Interval Between Onset and Death <i>One year</i>			
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST				a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Asbestosis. Chronic obstructive lung disease. Congestive heart failure. CAD</i>				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 28d. DESCRIBE HOW INJURY OCCURED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>Chang H. Oh, M.D.</i>			
29c. LICENSE NUMBER <i>D24951</i>				29d. DATE SIGNED (Month, Day, Year) <i>April 20, 95</i>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Chang H. Oh, M.D.; 48 Tarn Terrace, Suite 204: Frostburg, Md. 21532</i>							
31. DATE FILED (Month, Day, Year) <i>APR 21 1995</i>				32. REGISTRAR'S SIGNATURE <i>Sharon Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13606

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MICHAEL PERRIN				2. DATE OF DEATH MONTH DAY YEAR April 15, 1995		3. TIME OF DEATH 10:25 P M	
4. SOCIAL SECURITY NUMBER 220-38-0446		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 87 YRS.		7. DATE OF BIRTH (Month, Day, Year) May 25, 1907	
8. BIRTHPLACE (State or Foreign Country) Pennsylvania				9. FACILITY NAME (If not institution, give street and number) Memorial Hospital		10. CITY, TOWN OR LOCATION OF DEATH Cumberland	
11. COUNTY OF DEATH Allegany				12. RESIDENCE OF DECEDENT 10a. STATE Pennsylvania 10b. COUNTY Bedford		13. CITY, TOWN OR LOCATION Artemus	
14. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				15. STREET AND NUMBER HC-13 Box 13		16. ZIP CODE 17211	
17. CITIZEN OF WHAT COUNTRY? USA				18. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		19. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
20. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				21. RACE — American Indian, Black, White, etc. Specify: White		22. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College	
23. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Farmer				24. KIND OF BUSINESS/INDUSTRY Farming		25. FATHER'S NAME (First, Middle, Last) Charles H. Perrin	
26. MOTHER'S NAME (First, Middle, Maiden Surname) Rose Kennard				27. INFORMANT'S NAME (Type/Print) Charles M. Perrin		28. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) HCR-13 Box-11 Artemus, Penna.	
29. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				30. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Hillcrest Burial Park 19 APR 1995		31. LOCATION — City or Town, State Cumberland, Md.	
32. SIGNATURE OF FUNERAL SERVICE LICENSEE Ernest A. Rely. A.				33. NAME AND ADDRESS OF FACILITY Leasure-Stein, Inc. 230 Baltimore Avenue Cumberland, Md. 21502			
34. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → ACUTE CONGESTIVE HEART FAILURE Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. CHRONIC CONGESTIVE HEART FAILURE c. CORONARY ARTERY DISEASE							
35. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
36. 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				37. 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
38. 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Could not be determined				39. 28. DATE OF INJURY (Month, Day, Year) 19 APR 1995			
40. 29. TIME OF INJURY M				41. 30. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
42. 31. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				43. 32. DESCRIBE HOW INJURY OCCURRED			
44. 33. LOCATION (Street and Number or Rural Route Number, City or Town, State)				45. 34. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
46. 35. SIGNATURE AND TITLE OF CERTIFIER Dr. T. Williams				47. 36. LICENSE NUMBER D 16041			
48. 37. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. T. Williams, Memorial Hospital Medical Bldg., Cumberland, MD 21502				49. 38. DATE SIGNED (Month, Day, Year) 4-18-95			
50. 39. DATE FILED (Month, Day, Year) APR 19 1995				51. 40. REGISTRAR'S SIGNATURE John A. ...			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13607

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Lynda Sue Propst				2. DATE OF DEATH MONTH DAY YEAR April 10 1995				3. TIME OF DEATH 4:48AM M	
4. SOCIAL SECURITY NUMBER 219-78-0690		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 36 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Jul 15, 1958		8. BIRTHPLACE (State or Foreign Country) MD	
9a. FACILITY NAME (If not institution, give street and number) SACRED HEART HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH CUMBERLAND			9c. COUNTY OF DEATH ALLEGANY		
RESIDENCE OF DECEDENT									
10a. STATE MD		10b. COUNTY Allegany		10c. CITY, TOWN OR LOCATION Cumberland				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 218 Columbia Street Apt				10f. ZIP CODE 21502		10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: white		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College (1-4 or 5+)			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Secretary			16b. KIND OF BUSINESS/INDUSTRY Sacred Heart Hospital			
17. FATHER'S NAME (First, Middle, Last) Leo F. Robinette					18. MOTHER'S NAME (First, Middle, Maiden Surname) Myrtle P. Ruby				
19a. INFORMANT'S NAME (Type/Print) Harold J. Propst				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 218 Columbia Street Apt 303 Cumberland, MD 21502					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Mt. Tabor Cemetery		DATE 04/12		20c. LOCATION — City or Town, State Oldtown, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James F. Scarpelli</i>				22. NAME AND ADDRESS OF FACILITY Scarpelli Funeral Home Cumberland, MD 21502					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Massive pelvic bleed DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. Disseminated Intravascular Coagulopathy DUE TO (OR AS A CONSEQUENCE OF): c. Post operative salpingectomy DUE TO (OR AS A CONSEQUENCE OF): d. Ruptured left ectopic pregnancy								Approximate Interval Between Onset and Death 2 hours 2 hours 3 days 3 days	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Paul Snow</i> Duty Med Ex				29c. LICENSE NUMBER D 09157		29d. DATE SIGNED (Month, Day, Year) April 11, 1995			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Paul Snow, M.D. 124 w 3rd st Cumb MD 21502									
31. DATE FILED (Month, Day, Year) APR 12 1995		32. REGISTRAR'S SIGNATURE <i>John H. Harkell</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13608

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) HARRY WALTER PETERS				2. DATE OF DEATH MONTH APRIL DAY 8 YEAR 1995		3. TIME OF DEATH 10:30 A^M	
4. SOCIAL SECURITY NUMBER 351-16-4234		5. SEX 1 <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 69 YRS.		7. DATE OF BIRTH (Month, Day, Year) JULY 7 1925	
8. BIRTHPLACE (State or Foreign Country) ILL.				9a. FACILITY NAME (If not institution, give street and number) SACRED HEART HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH CUMBERLAND	
9c. COUNTY OF DEATH ALLEGANY				10a. STATE MARYLAND		10b. COUNTY ALLEGANY	
10c. CITY, TOWN OR LOCATION LAVALE				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 13802 BRIARWOOD DRIVE S.W.	
10f. ZIP CODE 21502				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES US NAVY WWII				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: WHITE				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CSX RAILROAD WELDING DIV.				16b. KIND OF BUSINESS/INDUSTRY RAILROAD			
17. FATHER'S NAME (First, Middle, Last) WALTER PETERS				18. MOTHER'S NAME (First, Middle, Maiden Surname) MINNIE GANZER			
19a. INFORMANT'S NAME (Type/Print) MARJORIE PETERS				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13802 BRIARWOOD DRIVE S.W. LAVALE MARYLAND 21502			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium or other place) ROCKY GAP VETERANS CEMETERY			
20c. DATE APRIL 11 1995				20d. LOCATION — City or Town, State FLINTSTONE MD.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Dale L. Merritt</i>				22. NAME AND ADDRESS OF FACILITY MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Profound sepsis DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. Peritonitis DUE TO (OR AS A CONSEQUENCE OF): c. Ruptured sigmoid colon DUE TO (OR AS A CONSEQUENCE OF): d. Aorta removed by Port graft							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. - Severe atherosclerosis - Myocardial infarction DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Other (Specify)				28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 28d. DESCRIBE HOW INJURY OCCURRED 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> M.D.				29c. LICENSE NUMBER 013233		29d. DATE SIGNED (Month, Day, Year) APRIL 9, 95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 915 Sehon Dr. Cumberland Md. 21502							
31. DATE FILED (Month, Day, Year) APR 12 1995				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.


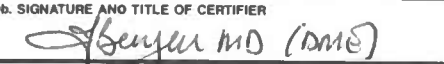

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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95 13609

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ROBERT McDONALD QUINN				2. DATE OF DEATH MONTH APRIL DAY 21 YEAR 1995		3. TIME OF DEATH ~ 7:00 A M	
4. SOCIAL SECURITY NUMBER 377-20-8061		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 69 YRS.		7. DATE OF BIRTH (Month, Day, Year) January 7, 1926	
8. BIRTHPLACE (State or Foreign Country) Michigan				9a. FACILITY NAME (If not institution, give street and number) 17710 Indian Head Hwy.		9b. CITY, TOWN OR LOCATION OF DEATH Accokeek	
9c. COUNTY OF DEATH PRINCE GEORGES				10a. STATE Maryland		10b. COUNTY Prince George	
10c. CITY, TOWN OR LOCATION Accokeek				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 17710 Indian Head Hwy	
10f. ZIP CODE 20607				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1944 - 1946				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: White				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 1			
16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Airplane Mechanic				17b. KIND OF BUSINESS/INDUSTRY Airlines			
17. FATHER'S NAME (First, Middle, Last) James Quinn				18. MOTHER'S NAME (First, Middle, Maiden Surname) Kathleen Doyle			
19a. INFORMANT'S NAME (Type/Print) Susana Quinn				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 156, Bryans Road, Md. 20616			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) April 27, 1995 Maryland Veterans Cem.			
20c. LOCATION — City or Town, State Cheltenham, Maryland				21. SIGNATURE OF FUNERAL SERVICE LICENSEE  M00668			
22. NAME AND ADDRESS OF FACILITY Williams Funeral Home, P.A. Rt. 225 & Glymont Rd., Indian Head, Md.				23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. Acute Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF): b. CORONARY Heart Disease DUE TO (OR AS A CONSEQUENCE OF): c. Generalized Atherosclerosis DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death minutes years years			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO				25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY M			
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER 			
29c. LICENSE NUMBER D25925				29d. DATE SIGNED (Month, Day, Year) April 21, 1995			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J. BERGER MD #205, 7720 Wisconsin Ave Bethesda, Md 20814							
31. DATE FILED (Month, Day, Year) APR 26 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BOX 68760

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

1 - STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

95 13610

DHMH-16 Rev 1/89

95 13611

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Milton Russell				2. DATE OF DEATH MONTH April DAY 18 YEAR 1995				3. TIME OF DEATH 2150 M	
4. SOCIAL SECURITY NUMBER 219-16-0404		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 71 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7. DATE OF BIRTH (Month, Day, Year) Aug. 18, 1923				8. BIRTHPLACE (State or Foreign Country) Maryland					
9a. FACILITY NAME (If not institution, give street and number) Calvert Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Prince Frederick				9c. COUNTY OF DEATH Calvert	
10a. STATE Maryland		10b. COUNTY Calvert		10c. CITY, TOWN OR LOCATION Prince Frederick				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 315 Sixes Road				10f. ZIP CODE 20678				10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Truck Driver				16b. KIND OF BUSINESS/INDUSTRY Freight	
17. FATHER'S NAME (First, Middle, Last) Isaac Russell				18. MOTHER'S NAME (First, Middle, Maiden Surname) Helen Stewart					
19a. INFORMANT'S NAME (Type/Print) Ella Louise Russell				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 315 Sixes Road Prince Frederick, MD 20678					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Mt. Olive UM Church Cem. 4/22/95				20c. LOCATION — City or Town, State Prince Frederick, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Spencer E. Sewell</i>				22. NAME AND ADDRESS OF FACILITY Sewell Funeral Home 1451 Dares Beach Rd. Prince Frederick, MD					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate interval Between Onset and Death	
a. CONGESTIVE HEART FAILURE DUE TO (OR AS A CONSEQUENCE OF):								1 yr	
b. CORONARY ARTERY DISEASE DUE TO (OR AS A CONSEQUENCE OF):									
c. DIABETES MELLITUS DUE TO (OR AS A CONSEQUENCE OF):									
d.									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO									
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28i. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Charles Judge</i>				29c. LICENSE NUMBER 089657				29d. DATE SIGNED (Month, Day, Year) 4/19/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Charles Judge, M.D. Prince Frederick, MD 20678									
31. DATE FILED (Month, Day, Year) APR 21 1995				32. REGISTRAR'S SIGNATURE <i>Julia Davidson Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13612

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) DAISY FAYE ROBINSON				2. DATE OF DEATH MONTH DAY YEAR April 18 1995		3. TIME OF DEATH 9:15 A.M.	
4. SOCIAL SECURITY NUMBER 249-01-9201		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 83 YRS.		7. DATE OF BIRTH (Month, Day, Year) May 14, 1911	
8. BIRTHPLACE (State or Foreign Country) N.C.				9a. FACILITY NAME (If not institution, give street and number) 463 Tumbleweed Trail		9b. CITY, TOWN OR LOCATION OF DEATH Lusby	
9c. COUNTY OF DEATH Calvert				10a. STATE Maryland		10b. COUNTY Calvert	
10c. CITY, TOWN OR LOCATION Solomons				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER P.O. Box 1472 Solomons, Md.	
10f. ZIP CODE 20688				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8th Grade College (1-4 or 5+) Waitress				16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Waitress		16b. KIND OF BUSINESS/INDUSTRY Restaurant	
17. FATHER'S NAME (First, Middle, Last) Jacob Clontz				18. MOTHER'S NAME (First, Middle, Maiden Surname) Virgie Hough			
19a. INFORMANT'S NAME (Type/Print) Barbara Phillips				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as 10e			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Wash. Natl. Cem. April 21, 1995		20c. LOCATION — City or Town, State Suitland, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Michael O. Brown</i>				22. NAME AND ADDRESS OF FACILITY Raymond Funeral Home, P.A. 10684 So. Md. Blvd. Dunkirk, Md. 20754			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Congestive Heart Failure DUE TO (OR AS A CONSEQUENCE OF): b. Atherosclerotic cardiovascular disease DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CVA, Peto. U. Uter							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER 033123		29d. DATE SIGNED (Month, Day, Year) 4-18-95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Jonathon Lowenthal, M.D. 120 Hospital Dr., Prince Frederick, Md. 20678							
31. DATE FILED (Month, Day, Year) APR 20 1995				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13613

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>DIANE YVETTE RITTER</u>				2. DATE OF DEATH MONTH <u>APRIL</u> DAY <u>11</u> YEAR <u>95</u>		3. TIME OF DEATH <u>14:10</u> M	
4. SOCIAL SECURITY NUMBER <u>578-82-0256</u>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>26</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>Aug 7 1968</u>	
8. BIRTHPLACE (State or Foreign Country) <u>Washington DC</u>				9a. FACILITY NAME (If not institution, give street and number) <u>Holy Cross Hospital</u>		9b. CITY, TOWN OR LOCATION OF DEATH <u>Silver Spring</u>	
9c. COUNTY OF DEATH <u>Montgomery</u>				10a. STATE <u>D. C.</u>		10b. COUNTY <u>N/A</u>	
10c. CITY, TOWN OR LOCATION <u>Washington</u>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER <u>812 Somerset Place N. W.</u>	
10f. ZIP CODE <u>20011</u>				10g. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>Black</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>5+</u> College (1-4 or 5+) <u>5+</u>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Publications Specialist</u>		16b. KIND OF BUSINESS/INDUSTRY <u>Realtors</u> <u>Mongomery Co. Assoc of</u>	
17. FATHER'S NAME (First, Middle, Last) <u>Martin Ritter Jr.</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Vivian Lee Laws</u>			
19a. INFORMANT'S NAME (Type/Print) <u>Vivian Ritter</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>812 Somerset Place N W Washington D. C. 20011</u>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Memorial Park Gardens</u> <u>4-18</u>		20c. LOCATION — City or Town, State <u>Battle Creek Michigan</u>		21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>J P Marshall</u>	
22. NAME AND ADDRESS OF FACILITY <u>Marshall's Funeral Home Inc</u> <u>4217 9th Street, N. W.</u> <u>Washington, DC 20011</u>				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>PULMONARY EMBOLISM</u> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST <u>FRACTURE RIGHT ANKLE</u> DUE TO (OR AS A CONSEQUENCE OF): <u>OBSITY</u> DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death <u>ACUTE</u> <u>5 WKS</u>			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>OBSITY</u>				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>				25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			
28a. DATE OF INJURY (Month, Day, Year) <u>MARCH 7 95</u>		28b. TIME OF INJURY <u>P M</u>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED <u>FELL ON ICE</u>	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <u>STREET</u>				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <u>800 SOMERSET P. N.W. DC</u>			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <u>Francis M. Hyle</u>				29c. LICENSE NUMBER <u>D07099</u>		29d. DATE SIGNED (Month, Day, Year) <u>APRIL 11 95</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>FRANCIS M. HYLE 10215 FERNWOOD RD BETHESDA MD 20817 7106</u>							
31. DATE FILED (Month, Day, Year) <u>APR 13 1995</u>				32. REGISTRAR'S SIGNATURE <u>Johanna R. Ricketts</u>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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95 13614

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Elizabeth T. Royster</i>				2. DATE OF DEATH MONTH <i>April</i> DAY <i>6</i> YEAR <i>1995</i>				3. TIME OF DEATH <i>8:55A</i> M	
4. SOCIAL SECURITY NUMBER <i>578-20-0744</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) <i>79</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
9a. FACILITY NAME (If not institution, give street and number) <i>Doctor's Comm. Hospital</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Lanham</i>				9c. COUNTY OF DEATH <i>Prince George's</i>	
10a. STATE <i>Md.</i>				10b. COUNTY <i>P.G.</i>		10c. CITY, TOWN OR LOCATION <i>Glenn Dale</i>			
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <i>5100 Glenn Dale Rd.</i>		10f. ZIP CODE <i>20769</i>		10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>Black</i>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12th</i> College (1-4 or 5+) <i></i>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Secretary</i>		16b. KIND OF BUSINESS/INDUSTRY <i>D.C. Government</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Frederick Fletcher</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Harriett Jones</i>					
19a. INFORMANT'S NAME (Type/Print) <i>Ruth Brayboy</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>9018 Volta St., Lanham, Md. 20706</i>					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Harmony Mem. Park 4/11/95</i>		20c. LOCATION — City or Town, State <i>Landover, Md.</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Danny H. Pratt</i>				22. NAME AND ADDRESS OF FACILITY <i>H.S. Washington & Sons, Inc. 4925 Burroughs Ave., N.E.</i>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>acute infarct myocardial</i> a. DUE TO (OR AS A CONSEQUENCE OF): <i>arteriosclerotic heart disease</i> b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):								Approximate interval Between Onset and Death <i>12 hours</i> <i>years</i>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Emphysema</i> <i>asthma</i>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. Charles M.D.</i>							
29c. LICENSE NUMBER <i>D13339</i>		29d. DATE SIGNED (Month, Day, Year) <i>4/6/95</i>							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>T. CHANDLER M.D., 8824 Cunningham Drive, Bryn Mawr, Pa.</i>									
31. DATE FILED (Month, Day, Year) <i>APR 10 1995</i>		32. REGISTRAR'S SIGNATURE <i>J. H. H. H.</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) NANCY ALICE RITCHEY				2. DATE OF DEATH MONTH DAY YEAR APRIL 19 1995		3. TIME OF DEATH 04:00 A M	
4. SOCIAL SECURITY NUMBER 219-14-5260		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) 72 YRS.		7. DATE OF BIRTH (Month, Day, Year) Nov. 13, 1922	
9a. FACILITY NAME (If not institution, give street and number) SACRED HEART HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH CUMBERLAND, MD.				9c. COUNTY OF DEATH ALLEGANY	
10a. STATE Md				10b. COUNTY Allegany		10c. CITY, TOWN OR LOCATION Cumberland	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER 209 Maryland Avenue			
10f. ZIP CODE 21502				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Home	
17. FATHER'S NAME (First, Middle, Last) William Henry Spiker				18. MOTHER'S NAME (First, Middle, Maiden Surname) Charlotte Winifred			
19a. INFORMANT'S NAME (Type/Print) Wm. E. Ritchey				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15402 Lower Georges Creek Rd., Frostburg, Md. 21532			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Frostburg Mem. Park April 21, 1995		20c. LOCATION — City or Town, State Frostburg, Md.		21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James E. McKenzie</i>	
22. NAME AND ADDRESS OF FACILITY Eichhorn-McKenzie Funeral Home Lonaconing, Md. 21539				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Diabetic Bowel Disease DUE TO (OR AS A CONSEQUENCE OF): Diabetes Mellitus Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death ONE 1/2 years UNKNOWN			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Nomicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED 				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Robert Welik</i>				29c. LICENSE NUMBER 031875		29d. DATE SIGNED (Month, Day, Year) APRIL 19/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. ROBERT WELIK, M.D., 902 SETON DRIVE, CUMBERLAND, MD 21502							
31. DATE FILED (Month, Day, Year) APR 21 1995				32. REGISTRAR'S SIGNATURE <i>Robert Welik</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13616

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Thomas A. Ricker SR.				2. DATE OF DEATH MONTH DAY YEAR April 18 1995		3. TIME OF DEATH 1:40 PM	
4. SOCIAL SECURITY NUMBER 215-20-5184		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 69 YRS.		7. DATE OF BIRTH (Month, Day, Year) FEB 6 1926	
8. BIRTHPLACE (State or Foreign Country) MARYLAND				9a. FACILITY NAME (If not institution, give street and number) CUMBERLAND NURSING HOME		9b. CITY, TOWN OR LOCATION OF DEATH CUMBERLAND	
9c. COUNTY OF DEATH ALLEGANY				10a. STATE MARYLAND		10b. COUNTY ALLEGANY	
10c. STREET AND NUMBER 1049 NATIONAL HIGHWAY				10d. ZIP CODE 21502		10e. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES U.S. ARMY		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) KELLY SPRINGFIELD TIRE CO		16b. KIND OF BUSINESS/INDUSTRY MANUF. TIRES			
17. FATHER'S NAME (First, Middle, Last) GEORGE A. RICKER				18. MOTHER'S NAME (First, Middle, Maiden Surname) ANNA MARIE WOODS			
19a. INFORMANT'S NAME (Type/Print) ELIZABETH M. RICKER				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1049 NATIONAL HIGHWAY LAVALE, MARYLAND 21502			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) SUNSET CEMETERY APRIL 22 1995		20c. LOCATION — City or Town, State CUMBERLAND MARYLAND			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Dale L. Merritt				22. NAME AND ADDRESS OF FACILITY MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cardiac arrest							
DUE TO (OR AS A CONSEQUENCE OF): Chronic renal failure.							
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
DUE TO (OR AS A CONSEQUENCE OF):							
DUE TO (OR AS A CONSEQUENCE OF):							
DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Possible hyperbalemic.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Peter B. Halmos				29c. LICENSE NUMBER DOY981		29d. DATE SIGNED (Month, Day, Year) April 19, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) PETER B. HALMOS 302 Schlegel Cumberland, Md.							
31. DATE FILED (Month, Day, Year) APR 20 1995		32. REGISTRAR'S SIGNATURE Richard R. Rall					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13617

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) KENNETH RALPH RAAT				2. DATE OF DEATH MONTH APRIL DAY 23 YEAR 1995		3. TIME OF DEATH 1:45 P M	
4. SOCIAL SECURITY NUMBER 528-46-3927		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 58 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 3, 1936	
9a. FACILITY NAME (If not institution, give street and number) National Institute of Health				9b. CITY, TOWN OR LOCATION OF DEATH Bethesda		9c. COUNTY OF DEATH Montgomery	
RESIDENCE OF DECEDENT							
10a. STATE California		10b. COUNTY Orange		10c. CITY, TOWN OR LOCATION Santa Ana		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 2409 North Deodar Street				10f. ZIP CODE 92705		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Attorney		16b. KIND OF BUSINESS/INDUSTRY Law			
17. FATHER'S NAME (First, Middle, Last) Gerald Hugo Raat				18. MOTHER'S NAME (First, Middle, Maiden Surname) Grace Zondervon			
19a. INFORMANT'S NAME (Type/Print) Darlene Raat				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2409 North Deodar Street Santa Ana, Ca. 92705			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Fairhaven Memorial Park 4/28		20c. LOCATION — City or Town, State Santa Ana, Ca.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Gray S. Raat</i>				22. NAME AND ADDRESS OF FACILITY Donaldson Funeral Home P.A. 313 Talbott Avenue Laurel, Md. 20707			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. Cerebral Infarction DUE TO (OR AS A CONSEQUENCE OF):				Approximate Interval Between Onset and Death 3d	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST		b. Thromboembolism DUE TO (OR AS A CONSEQUENCE OF):				3d	
		c. Gastritis DUE TO (OR AS A CONSEQUENCE OF):				years	
		d.					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Tet Wei Chan</i>				29c. LICENSE NUMBER 0101043809 VA		29d. DATE SIGNED (Month, Day, Year) 4/24/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) TET WEI CHAN, M.D. 9000 ROCKVILLE PIKE, BETHESDA, MARYLAND 20892							
31. DATE FILED (Month, Day, Year) APR 27 1995				32. REGISTRAR'S SIGNATURE <i>John Andrew Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13618

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Elia Jones SPICER</u>				2. DATE OF DEATH MONTH <u>April</u> DAY <u>14</u> YEAR <u>1995</u>		3. TIME OF DEATH <u>8:13P</u> M	
4. SOCIAL SECURITY NUMBER <u>578-50-4188</u>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>89</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>Sept. 13, 1905</u>	
8. BIRTHPLACE (State or Foreign Country) <u>Alabama</u>				9a. FACILITY NAME (If not institution, give street and number) <u>Doctor's Community Hospital</u>		9b. CITY, TOWN OR LOCATION OF DEATH <u>Lanham</u>	
9c. COUNTY OF DEATH <u>Prince George's</u>				10a. STATE <u>Maryland</u>		10b. COUNTY <u>Prince George's</u>	
10c. CITY, TOWN OR LOCATION <u>Riverdale</u>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER <u>6321 Kenilworth Avenue</u>	
10f. ZIP CODE <u>20737</u>				10g. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>White</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) _____ College (1-4 or 5+) <u>2</u>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Librarian</u>		16b. KIND OF BUSINESS/INDUSTRY <u>United States Government</u>			
17. FATHER'S NAME (First, Middle, Last) <u>Alvin Staley Jones</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Maggie Pearl Smilie</u>			
19a. INFORMANT'S NAME (Type/Print) <u>Curtis J. Spicer</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>1876 Harcourt Avenue, Crofton, Maryland 21114</u>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Fort Lincoln Cemetery 04/17/95</u>		OATE		20c. LOCATION — City or Town, State <u>Brentwood, Maryland</u>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Charles F. Bell</u>				22. NAME AND ADDRESS OF FACILITY <u>Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>RESPIRATORY FAILURE</u> DUE TO (OR AS A CONSEQUENCE OF): a. <u>SEPTIC SHOCK.</u> b. <u>ENCEPHALOPATHY.</u> c. _____ d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>DJD; she was made-DNR.</u>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO <u>N/A</u>					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <u>[Signature]</u>				29c. LICENSE NUMBER <u>D-34525</u>		29d. DATE SIGNED (Month, Day, Year) <u>APR 15 1995</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>S-J-Rao, MD-4000 Mitchellville Road; #220; Bowie MD-20716</u>							
31. DATE FILED (Month, Day, Year) <u>APR 17 1995</u>		32. REGISTRAR'S SIGNATURE <u>Jahia Anderson-Randall</u>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13619

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) BEATRICE M. SCHREINER				2. DATE OF DEATH MONTH DAY YEAR APRIL 15, 1995		3. TIME OF DEATH 2:58 P.M.	
4. SOCIAL SECURITY NUMBER 179-01-1774		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 75 YRS.		7. DATE OF BIRTH (Month, Day, Year) NOV. 24, 1919	
8. BIRTHPLACE (State or Foreign Country) DELAWARE				9a. FACILITY NAME (If not institution, give street and number) 10716 PINEY ISLAND DRIVE		9b. CITY, TOWN OR LOCATION OF DEATH BISHOPVILLE	
9c. COUNTY OF DEATH WORCESTER				10a. STATE MARYLAND		10b. COUNTY WORCESTER	
10c. CITY, TOWN OR LOCATION BISHOPVILLE				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 10716 PINEY ISLAND DRIVE	
10f. ZIP CODE 21813				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) _____		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) OWNER & OPERATOR		16b. KIND OF BUSINESS/INDUSTRY MOTEL			
17. FATHER'S NAME (First, Middle, Last) WILLIAM GODFREY				18. MOTHER'S NAME (First, Middle, Maiden Surname) ELIZABETH SAVAGE			
19a. INFORMANT'S NAME (Type/Print) PAUL D. FRANK				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. BOX 352, SPENCER, NEW YORK 14883			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) _____		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) EVERGREEN CEMETERY		DATE 4/19/95		20c. LOCATION — City or Town, State BERLIN, MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Charles W. Hastings</i>				22. NAME AND ADDRESS OF FACILITY HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Cancer of liver</i> DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. _____ DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____ _____						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO						DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) _____					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) _____ 28b. TIME OF INJURY M _____ 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED _____ 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) _____ 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) _____			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER 126040		29d. DATE SIGNED (Month, Day, Year) 4/18/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) CRAIG J. SCHAEFER 551 A RIVERSIDE DR. SAUSBURY, MD. 21801							
31. DATE FILED (Month, Day, Year) APR 18 1995				32. REGISTRAR'S SIGNATURE <i>Johanna R. Riddell</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13620

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) VIRGIL LEE SWICK				2. DATE OF DEATH MONTH DAY YEAR APRIL 24, 1995		3. TIME OF DEATH 1200 NOON	
4. SOCIAL SECURITY NUMBER 233-34-7458		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 70 YRS.		7. DATE OF BIRTH (Month, Day, Year) MARCH 14, 1925	
8. BIRTHPLACE (State or Foreign Country) WEST VIRGINIA				9. CITY, TOWN OR LOCATION OF DEATH WESTMINSTER		10. COUNTY OF DEATH CARROLL	
9a. FACILITY NAME (If not institution, give street and number) 3316 HALTER ROAD							
10a. STATE MARYLAND							
10b. COUNTY CARROLL							
10c. CITY, TOWN OR LOCATION WESTMINSTER							
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER 3316 HALTER ROAD							
10f. ZIP CODE 21158							
10g. CITIZEN OF WHAT COUNTRY? USA							
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES WORLD WAR II		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Year or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: CAUCASIAN	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9th College (1-4 or 5+) College				16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) INSTALLER		16b. KIND OF BUSINESS/INDUSTRY ELECTRICAL MANUFACTURER	
17. FATHER'S NAME (First, Middle, Last) GLENN SWICK				18. MOTHER'S NAME (First, Middle, Maiden Surname) RHODA CATHERINE WRATCHFORD			
19a. INFORMANT'S NAME (Type/Print) ROBERT L. SWICK				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 600 MARWOOD ROAD TOWSON, MARYLAND 21204			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MAPLE HILL CEMETERY		20c. LOCATION — City or Town, State 4/27 PETERSBURG, W.V.		20d. DATE 4/27	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>P. Kevin Judy</i>				22. NAME AND ADDRESS OF FACILITY 136 EAST BALTIMORE STREET SKILES FUNERAL HOME TANEYTOWN, MD 21787			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic Cardiovascular disease DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. DATE SIGNED (Month, Day, Year) APRIL 25, 1995			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>Sang Y. Rhim</i>			
29c. LICENSE NUMBER D14209(MD)				29d. DATE SIGNED (Month, Day, Year) APRIL 25, 1995			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SANG Y. RHIM, M.D. 212 WASHINGTON HEIGHTS WESTMINSTER, MARYLAND 21157							
31. DATE FILED (Month, Day, Year) APR 25 1995				32. REGISTRAR'S SIGNATURE <i>Julia Anderson</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020


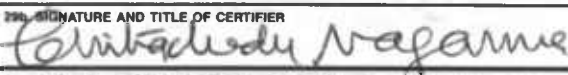
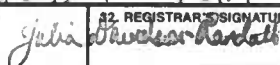
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13621

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Sophia Eleanor Schubert				2. DATE OF DEATH MONTH DAY YEAR April 22, 1995		3. TIME OF DEATH 5:00P.M.	
4. SOCIAL SECURITY NUMBER 195-18-7975		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (in yrs. last birthday) 72 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 24 1922	
9a. FACILITY NAME (If not institution, give street and number) CARROLL COUNTY GENERAL HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH WESTMINSTER		9c. COUNTY OF DEATH CARROLL	
10a. STATE Maryland		10b. COUNTY Carroll		10c. CITY, TOWN OR LOCATION Westminster		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 30 Locust St. Apt. 308				10f. ZIP CODE 21157		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife		16b. KIND OF BUSINESS/INDUSTRY Homemaker			
17. FATHER'S NAME (First, Middle, Last) Matthew Seboroski				18. MOTHER'S NAME (First, Middle, Maiden Surname) Eleanor			
19a. INFORMANT'S NAME (Type/Print) Jerome A. Schubert				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1511 Dulany Rd. Finksburg, Md. 21048			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Carroll Cremation		DATE 4/25		20c. LOCATION — City or Town, State Hampstead, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Fletcher Funeral Home 21157 254 East Main Street, Westminster, Md.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CEREBROVASCULAR ACCIDENT DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate Interval Between Onset and Death 10 Hours	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETES MELLITUS Systemic Hypertension						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO						26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER 			
29c. LICENSE NUMBER D18200				29d. DATE SIGNED (Month, Day, Year) 4/23/95			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) CHITRACHEDU NAGANMA 700-A POLO RD WESTMINSTER MD 21157							
31. DATE FILED (Month, Day, Year) APR 25 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13622

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) Lillian B. Spicer				2. DATE OF DEATH MONTH DAY YEAR April 20 1995		3. TIME OF DEATH 1145 M	
4. SOCIAL SECURITY NUMBER 216-03-2369		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 82 YRS.		7. DATE OF BIRTH (Month, Day, Year) Dec. 13, 1912	
9a. FACILITY NAME (If not institution, give street and number) Dorchester General Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Cambridge		9c. COUNTY OF DEATH Dorchester	
10a. STATE Maryland		10b. COUNTY Dorchester		10c. CITY, TOWN OR LOCATION Taylors Island		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER P.O. Box 3				10f. ZIP CODE 21669		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Clerical		16b. KIND OF BUSINESS/INDUSTRY Moving and Storage	
17. FATHER'S NAME (First, Middle, Last) Joseph Kraus				16. MOTHER'S NAME (First, Middle, Maiden Surname) Catherine Buck			
19a. INFORMANT'S NAME (Type/Print) John S. Neild, Jr.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5110 North Drive, Cambridge, MD. 21613			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Grace Episcopal Chrch Cem 4-24		DATE April 12, 1995		20c. LOCATION — City or Town, State Taylors Island, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>William Brown</i>				22. NAME AND ADDRESS OF FACILITY Curran-Bromwell Funeral Home, P.A. 308 High St., Cambridge, MD. 21613			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Liver Failure DUE TO (OR AS A CONSEQUENCE OF): Cirrhosis of liver, probably from Hepatitis DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST						Approximate Interval Between Onset and Death April 12, 1995 April 20, 1995	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO						DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Jose M. deLeon, M.D.</i>				29c. LICENSE NUMBER X16316		29d. DATE SIGNED (Month, Day, Year) April 20, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Jose M. deLeon, M.D. 505 Byrn Street Cambridge, MD 21613							
31. DATE FILED (Month, Day, Year) APR 24 1995				32. REGISTRAR'S SIGNATURE <i>Julia Anderson Randall</i>			

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13623

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Elsie Mae Smith				2. DATE OF DEATH MONTH April DAY 17 YEAR 1995		3. TIME OF DEATH 2032 M	
4. SOCIAL SECURITY NUMBER 217-30-8017		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 88 YRS.		7. DATE OF BIRTH (Month, Day, Year) Mar. 22, 1907	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER		9b. CITY, TOWN OR LOCATION OF DEATH SALISBURY	
9c. COUNTY OF DEATH WICOMICO				10a. STATE Maryland		10b. COUNTY Worcester	
10c. CITY, TOWN OR LOCATION Pocomoke City Md.				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 429 Bank Street Pocomoke City, Md.	
10f. ZIP CODE 21851				10g. CITIZEN OF WHAT COUNTRY? United States		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) 7grade				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Domestic Work		16b. KIND OF BUSINESS/INDUSTRY House Keeper	
17. FATHER'S NAME (First, Middle, Last) Edward Long				18. MOTHER'S NAME (First, Middle, Maiden Surname) Leah Quinn			
19a. INFORMANT'S NAME (Type/Print) ELMER SMITH				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1805 CYPRESS RD., POCOMOKE, MD. 21851			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) Trinity				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gen. Unionville		20c. LOCATION — City or Town, State Pocomoke City, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY P.O. Box 46 3812 Davis Rd. Savage Funeral Home New Church, Va. 23415			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → END STAGE RENAL DISEASE							
DUE TO (OR AS A CONSEQUENCE OF): GD BLEEDING							
DUE TO (OR AS A CONSEQUENCE OF): HTN							
DUE TO (OR AS A CONSEQUENCE OF): CVA							
Approximate interval Between Onset and Death 2 1/2 YR. 1 Day. 20 YR. 8 YR.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ASCVD, CHF, DM,							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE NOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Leash Gooden MD				29c. LICENSE NUMBER D32014		29d. DATE SIGNED (Month, Day, Year) 4/18/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MAHEH MOONDR 547 E RIVERSIDE DRIVE SALISBURY MD 21801.							
31. DATE FILED (Month, Day, Year) APR 21 1995				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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95 13624

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) Richard J. Schaufert				2. DATE OF DEATH MONTH April DAY 14 YEAR 1995		3. TIME OF DEATH 0729 M	
4. SOCIAL SECURITY NUMBER 215-14-4941		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 74 YRS.		7. DATE OF BIRTH (Month, Day, Year) 8-29-1920	
8. BIRTHPLACE (State or Foreign Country) Pennsylvania				9a. FACILITY NAME (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER		9b. CITY, TOWN OR LOCATION OF DEATH SALISBURY	
9c. COUNTY OF DEATH WICOMICO				10a. STATE Maryland		10b. COUNTY Somerset	
10c. CITY, TOWN OR LOCATION Marion Station				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 4719 Shelltown Road	
10f. ZIP CODE 21838				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12				16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Machinest		16b. KIND OF BUSINESS/INDUSTRY Carvel Hall Cutlery	
17. FATHER'S NAME (First, Middle, Last) Paul R. Schaufert				18. MOTHER'S NAME (First, Middle, Maiden Surname) Amanda Gable			
19a. INFORMANT'S NAME (Type/Print) Kathryn S. Schaufert				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4719 Shelltown Rd., Marion Station, Md. 21838			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Remson Methodist Cemetery 4/17		20c. LOCATION — City or Town, State Pocomoke, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Scott S. Nelson				22. NAME AND ADDRESS OF FACILITY Nelson Funeral Home PO Box 64, Pocomoke City, Md. 21851			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CARDIAC ARREST DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. RUPTURED ILIAC ARTERY DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER [Signature]				29c. LICENSE NUMBER 720000		29d. DATE SIGNED (Month, Day, Year) 4/14/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Craig Schaefer 551 Riverside Dr. Salisbury, Md. 21801							
31. DATE FILED (Month, Day, Year) APR 21 1995				32. REGISTRAR'S SIGNATURE [Signature]			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

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95 13625

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Grace B. Stuffle</u>		2. DATE OF DEATH MONTH <u>April</u> DAY <u>21</u> YEAR <u>95</u>		3. TIME OF DEATH <u>9 AM</u>	
4. SOCIAL SECURITY NUMBER <u>190-12-3430</u>		5. SEX <u>Female</u>		6. AGE (In yrs. last birthday) <u>71</u> YRS.	
7. DATE OF BIRTH (Month, Day, Year) <u>August 29, 1923</u>		8. BIRTHPLACE (State or Foreign Country) <u>PA</u>		9. FACILITY NAME (If not institution, give street and number) <u>Mercy Medical Center</u>	
10. CITY, TOWN OR LOCATION OF DEATH <u>Baltimore</u>		11. COUNTY OF DEATH <u>Baltimore</u>		12. RESIDENCE OF DECEDENT	
10a. STATE <u>MD</u>		10b. COUNTY <u>Carroll</u>		10c. CITY, TOWN OR LOCATION <u>Westminster</u>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <u>1510 E. Mayberry Rd.</u>		10f. ZIP CODE <u>21158</u>	
10g. CITIZEN OF WHAT COUNTRY? <u>USA</u>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>White</u>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u>Operator</u>	
16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Operator</u>		16b. KIND OF BUSINESS/INDUSTRY <u>United Telephone</u>		17. FATHER'S NAME (First, Middle, Last) <u>Horace Schue</u>	
18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Sarah Phillips</u>		19a. INFORMANT'S NAME (Type/Print) <u>John J. Stuffle</u>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>1510 E. Mayberry Rd. Westminster, MD 21158</u>	
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Rest Haven Cemetery</u> DATE <u>4/25</u>		20c. LOCATION — City or Town, State <u>Hanover, PA</u>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Richard Little Jr.</u>		22. NAME AND ADDRESS OF FACILITY <u>Littles' F.H. 34 Maple Ave. Littlestown, PA 17340</u>		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Bleeding</u> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <u>Thrombocytopenia</u> <u>PRE Leukemia</u> <u>Multiple Myeloma</u>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Leucopenia</u>		24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <u>M</u>	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <u>Monica C. LeDonovan MD</u>		29c. LICENSE NUMBER <u>007930</u>		29d. DATE SIGNED (Month, Day, Year) <u>April 21, 1995</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>MARVIN FELDMAN 301 St. Paul Place Baltimore, Md 21202</u>					
31. DATE FILED (Month, Day, Year) <u>APR 27 1995</u>		32. REGISTRAR'S SIGNATURE <u>John Hamilton</u>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ZEB EDWARD SHEETS				2. DATE OF DEATH MONTH DAY YEAR April 2, 1995		3. TIME OF DEATH 3:55 am	
4. SOCIAL SECURITY NUMBER 578-09-4967		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 80 YRS.		7. DATE OF BIRTH (Month, Day, Year) Mar. 7, 1915	
9a. FACILITY NAME (If not institution, give street and number) Doctors Community Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Lanham, MD		9c. COUNTY OF DEATH Prince Georges	
10a. STATE Maryland				10b. COUNTY Prince George's		10c. CITY, TOWN OR LOCATION Lanham	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 9305 Alcona Street			
10f. ZIP CODE 20706				10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Furniture Salesman		16b. KIND OF BUSINESS/INDUSTRY Furniture Store			
17. FATHER'S NAME (First, Middle, Last) William Sheets				18. MOTHER'S NAME (First, Middle, Maiden Surname) Lillian (Unknown)			
19a. INFORMANT'S NAME (Type/Print) Kathleen G. Houser				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3008 Cedar Way, Upper Marlboro, Maryland 20772			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Fort Lincoln Cemetery 4/6/95		20c. LOCATION — City or Town, State Brentwood, Maryland		20d. DATE 4/6/95	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Mark A. Gudy				22. NAME AND ADDRESS OF FACILITY Fort Lincoln Funeral Home, Inc. 3401 Bladensburg Rd., Brentwood, MD 20722			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Respiratory Arrest DUE TO (OR AS A CONSEQUENCE OF): b. Pneumonia DUE TO (OR AS A CONSEQUENCE OF): c. Infection 1058 DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Dr. Margaret A. ...				29c. LICENSE NUMBER D31528		29d. DATE SIGNED (Month, Day, Year) April 3, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Margaret A. ... Landover Road, Cheverly, MD 20785							
31. DATE FILED (Month, Day, Year) APR 10 1995							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13627

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) James SMITH				2. DATE OF DEATH MONTH April , DAY 8 , YEAR 1995		3. TIME OF DEATH 12:45 A. M.	
4. SOCIAL SECURITY NUMBER 209-05-0557		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 86 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0	IF UNDER 24 HRS. HOURS 0 MIN. 0	7. DATE OF BIRTH (Month, Day, Year) Feb. 16, 1909	
9a. FACILITY NAME (If not institution, give street and number) Doctors Community Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Lanham		9c. COUNTY OF DEATH Prince Georges	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Prince George's		10c. CITY, TOWN OR LOCATION Greenbelt		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 19 F Ridge Road				10f. ZIP CODE 20770		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Chief of Plant Maintenance		16b. KIND OF BUSINESS/INDUSTRY U.S. Government			
17. FATHER'S NAME (First, Middle, Last) Thomas Smith				18. MOTHER'S NAME (First, Middle, Maiden Surname) Margaret Horlick			
19a. INFORMANT'S NAME (Type/Print) Stephen J. Smith				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 544, North Beach, Maryland 20714			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gate of Heaven Cem. 4/12/95		20c. LOCATION — City or Town, State Silver Spring, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE W.B. Gerson				22. NAME AND ADDRESS OF FACILITY Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pneumonia. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Parkinsonism, Dementia, Benign Prostatic Hypertrophy, Renal Insufficiency.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURRED			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TYPE OF CERTIFIER Stuart J. Turkewitz				29c. LICENSE NUMBER D31001		29d. DATE SIGNED (Month, Day, Year) 4/8/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Stuart J. Turkewitz, MD 7500 Greenbelt Center Drive #430 Greenbelt, MD 20770							
31. DATE FILED (Month, Day, Year) APR 10 1995		32. REGISTRAR'S SIGNATURE John A. ...					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95-1997-031

blh

95 13628

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Elba Yanira Sanchez				2. DATE OF DEATH MONTH April DAY 08 YEAR 1995		3. TIME OF DEATH 1950 M	
4. SOCIAL SECURITY NUMBER 212-33-0650		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 22 YRS.		7. DATE OF BIRTH (Month, Day, Year) 11 23 72	
8. BIRTHPLACE (State or Foreign Country) EL SALVADOR				9a. FACILITY NAME (If not institution, give street and number) 9737 Mount Pisgah Road		9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring	
9c. COUNTY OF DEATH Montgomery				10a. STATE MD		10b. COUNTY MONTGOMERY	
10c. CITY, TOWN OR LOCATION SILVER SPRING				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 9737 MOUNT PISGAH ROAD #302	
10f. ZIP CODE 20904				10g. CITIZEN OF WHAT COUNTRY? EL SALVADOR			
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: HISPANIC	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8TH College (1-4 or 5+) CASHIER		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CASHIER		16b. KIND OF BUSINESS/INDUSTRY WENDY'S RESTAURANT			
17. FATHER'S NAME (First, Middle, Last) LUIS R. GARCIA				18. MOTHER'S NAME (First, Middle, Maiden Surname) DAYSI SANCHEZ			
19a. INFORMANT'S NAME (Type/Print) LUIS R. GARCIA (FATHER)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2014 CAMBRIDGE ST. LOS ANGELES, CALIF. 90006			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) IPC-BU SIESA PLOT 4/18/95 MANCHESTER CLAPE		20c. LOCATION — City or Town, State		20d. DATE 4/18/95	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE W. H. Bacon 276				22. NAME AND ADDRESS OF FACILITY W.H. BACON FUNERAL HOME INC. 3447 14TH STREET, N.W. WASH, D.C. 20010			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → GUNSHOT WOUND OF HEAD DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 4/8/95 FOUND		28b. TIME OF INJURY 1000 PM		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED SUBJECT SHOT		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) APARTMENT		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 9737 MOUNT PISGAH, SILVER SPRING MD			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Mario F. Gomez MD				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) April 09 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARIO F. GOMEZ MD 111 Penn Street, Baltimore Maryland 21201							
31. DATE FILED (Month, Day, Year) APR 12 1995		32. REGISTRAR'S SIGNATURE Julia Davidson-Rodall					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

3

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13629

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) GLORIA SMITH				2. DATE OF DEATH MONTH APRIL DAY 7 YEAR 1995		3. TIME OF DEATH 3:30 p.m.	
4. SOCIAL SECURITY NUMBER 578-52-3704		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 56 YRS.		7. DATE OF BIRTH (Month, Day, Year) October 4, 1938	
8. BIRTHPLACE (State or Foreign Country) Washington, D.C.				9a. FACILITY NAME (If not institution, give street and number) Prince George's Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Cheverly	
9c. COUNTY OF DEATH PRINCE GEORGES				10a. STATE District of Columbia		10b. COUNTY Washington	
10c. CITY, TOWN OR LOCATION Washington				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 4302 Gorman Terrace, S.E.	
10f. ZIP CODE 20019				10g. CITIZEN OF WHAT COUNTRY? United States		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) None				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) None		16b. KIND OF BUSINESS/INDUSTRY N/A	
17. FATHER'S NAME (First, Middle, Last) James Clomax				18. MOTHER'S NAME (First, Middle, Maiden Surname) Beatrice Cook			
19a. INFORMANT'S NAME (Type/Print) Roscoe Barnes				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4302 Gorman Terrace, S.E. Wash., D.C. 20019			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Harmony Memorial Park 4/15/95		20c. LOCATION — City or Town, State Landover, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John T. Stewart, III</i>				22. NAME AND ADDRESS OF FACILITY Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 20019			
23. PART I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute Myocardial Infarct DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. CORONARY ARTERY DISEASE DUE TO (OR AS A CONSEQUENCE OF): c. HYPERTENSION DUE TO (OR AS A CONSEQUENCE OF): d. DIABETES MELLITUS							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) DURING A WALK OUTSIDE			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Bergner MD DME</i>				29c. LICENSE NUMBER D25925		29d. DATE SIGNED (Month, Day, Year) Apr 7, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J. BERGER MD #205, 7720 Wisconsin Ave Bethesda, Md 20814							
31. DATE FILED (Month, Day, Year) APR 12 1995				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Hendall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13630

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Evelyn Virginia Shaff				2. DATE OF DEATH MONTH April DAY 22 YEAR 1995		3. TIME OF DEATH 3:02 P M	
4. SOCIAL SECURITY NUMBER 215-14-2596		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 79 YRS.		7. DATE OF BIRTH (Month, Day, Year) Nov. 30, 1915	
9a. FACILITY NAME (If not institution, give street and number) Frederick Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Frederick		9c. COUNTY OF DEATH Frederick	
10a. STATE Maryland		10b. COUNTY Frederick		10c. CITY, TOWN OR LOCATION Knoxville		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 2559 Point of Rocks Road				10f. ZIP CODE 21758		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) Lawrence Alvin Pearl				18. MOTHER'S NAME (First, Middle, Maiden Surname) Catherine Lapole			
19a. INFORMANT'S NAME (Type/Print) Wayne V. Shaff				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5419 St. Andrews Drive, Salisbury, Md. 21801			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) St. Mark's Cemetery		20c. DATE Apr. 26, 1995		20d. LOCATION — City or Town, State Petersville, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Richard C.C. Gasford 20001				22. NAME AND ADDRESS OF FACILITY Keeney and Basford Funeral Home 106 East Church St., Frederick, Md. 21701			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. Sepsis DUE TO (OR AS A CONSEQUENCE OF):				Approximate Interval Between Onset and Death dys	
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. Ischemic & gangrenous Left foot DUE TO (OR AS A CONSEQUENCE OF):				dys	
		c. Right lower lobe pneumonia DUE TO (OR AS A CONSEQUENCE OF):				weeks	
		d. Possible lung neoplasm				weeks.	
		PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Gall stones, biliary stasis				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO		24c. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>	
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER J.P. Henry				29c. LICENSE NUMBER D35553		29d. DATE SIGNED (Month, Day, Year) 4/22/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J.P. Henry 610 9th Ave, Brunswick, MD 21716							
31. DATE FILED (Month, Day, Year) APR 24 1995				32. REGISTRAR'S SIGNATURE John Andrew Parfitt			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13631

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Diana Saul				2. DATE OF DEATH MONTH DAY YEAR April 21, 1995		3. TIME OF DEATH 5:42 A M	
4. SOCIAL SECURITY NUMBER 004-20-0799		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 69 YRS.		7. DATE OF BIRTH (Month, Day, Year) Dec. 2, 1925	
9a. FACILITY NAME (If not institution, give street and number) Frederick Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Frederick		9c. COUNTY OF DEATH Frederick	
10a. STATE Maryland				10b. COUNTY Frederick		10c. CITY, TOWN OR LOCATION Thurmont	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 15 Sunny Close			
10f. ZIP CODE 21788				10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Resident Manager		16b. KIND OF BUSINESS/INDUSTRY Apartment Rental	
17. FATHER'S NAME (First, Middle, Last) Maurice Wesley Greenlaw				18. MOTHER'S NAME (First, Middle, Maiden Surname) Florence Alice Anderson			
19a. INFORMANT'S NAME (Type/Print) Diana L. Beebe				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6414 Greyfield Rd., Fayetteville, N.C. 28303			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Hagerstown Crematory		20c. LOCATION — City or Town, State 4/25 Hagerstown, Maryland		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Paul P. B. Mackay				22. NAME AND ADDRESS OF FACILITY Stauffer Funeral Homes, P.A. 104 E. Main Street, Thurmont, MD 21788			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → CEREBRAL VASCULAR ACCIDENT DUE TO (OR AS A CONSEQUENCE OF): 5 DAYS Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST 5 YEARS ATRIAL FIBRILLATION DUE TO (OR AS A CONSEQUENCE OF): 5 YEARS							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HEPATIC CIRRHOSIS, BREAST CANCER							24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							25. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER Andrew O. Donelson, MD				29c. LICENSE NUMBER 021936		29d. DATE SIGNED (Month, Day, Year) 4.21.95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ANDREW O. DONELSON 915 TOLLHOUSE #203 FREDERICK 21701							
31. DATE FILED (Month, Day, Year) APR 24 1995				32. REGISTRAR'S SIGNATURE John Andrew Roshell			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13632

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) James Robert Smith, Sr.				2. DATE OF DEATH MONTH DAY YEAR Apr. 23 1995		3. TIME OF DEATH 5:15 a M	
4. SOCIAL SECURITY NUMBER 217-36-7044		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 55 YRS.		7. DATE OF BIRTH (Month, Day, Year) Aug 11 1939	
9a. FACILITY NAME (If not institution, give street and number) 12405 Hickory Tree Way				9b. CITY, TOWN OR LOCATION OF DEATH Germantown		9c. COUNTY OF DEATH Montgomery	
10a. STATE Md		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Germantown		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 12405 Hickory Tree Way Apt D				10f. ZIP CODE 20874		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yee or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) not employed		15e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) not employed		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) Lee Smith				16. MOTHER'S NAME (First, Middle, Maiden Surname) Beulah I. Nichols			
19a. INFORMANT'S NAME (Type/Print) Elizabeth Smith				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20874 12405 Hickory Tree Way Germantown, Md			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Monocacy 4/25		20c. LOCATION — City or Town, State Beallsville, Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Wm C. Hill</i>				22. NAME AND ADDRESS OF FACILITY Hilton Funeral Home Barnesville, Md. 20838			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Metastatic gastric Carcinoma DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death 6 month
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Smelshaw MD</i>		29c. LICENSE NUMBER D 33224		29d. DATE SIGNED (Month, Day, Year) APRIL 24, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) R Trehaw MD 504 Edmondson Dr #401, Rockville MD 20852							
31. DATE FILED (Month, Day, Year) APR 25 1995		32. REGISTRAR'S SIGNATURE <i>Julia Duckworth Radcliffe</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13633

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Leonard J. Sanders				2. DATE OF DEATH MONTH 4 DAY 19 YEAR 95		3. TIME OF DEATH 120 A M	
4. SOCIAL SECURITY NUMBER 215-32-5615		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 90 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0	IF UNDER 24 HRS. HOURS 0 MIN. 0	7. DATE OF BIRTH (Month, Day, Year) JULY 2, 1904	
9a. FACILITY NAME (If not institution, give street and number) ST. CATHERINE'S NURSING HOME				9b. CITY, TOWN OR LOCATION OF DEATH EMMITSBURG		9c. COUNTY OF DEATH FREDERICK	
10a. STATE MARYLAND				10b. COUNTY FREDERICK		10c. CITY, TOWN OR LOCATION EMMITSBURG	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER 17504 TRACT RD.				10f. ZIP CODE 21727		10g. CITIZEN OF WHAT COUNTRY? U. S. A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 0		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CLERK		16b. KIND OF BUSINESS/INDUSTRY POSTAL SERVICE			
17. FATHER'S NAME (First, Middle, Last) SAMUEL HILARY SANDERS				18. MOTHER'S NAME (First, Middle, Maiden Surname) CATHERINE BEARD			
19a. INFORMANT'S NAME (Type/Print) HELEN K. SANDERS				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17504 TRACT RD., EMMITSBURG, MD. 21727			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) SMITHSBURG CREMATORIUM		DATE		20c. LOCATION — City or Town, State SMITHSBURG, MD. 21783	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE John M. Skiles				22. NAME AND ADDRESS OF FACILITY SKILES FUNERAL HOME 210 W. MAIN ST., EMMITSBURG, MD. 21727			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) → Congestive Heart Failure Due to (or as a consequence of): Atherosclerotic Heart Disease Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Recent Pneumonia / UTI / COPD Adenocarcinoma of colon untreated							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, lecture, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURRED					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER Alan Carroll		29c. LICENSE NUMBER 018205		29d. DATE SIGNED (Month, Day, Year) 4/19/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ALAN CARROLL, M.D., 310 S. SETON AVE., EMMITSBURG, MD. 21727							
31. DATE FILED (Month, Day, Year) APR 21 1995				32. REGISTRAR'S SIGNATURE John A. Anderson			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH REG. NO.

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Gilbert Gerald Souder				2. DATE OF DEATH MONTH DAY YEAR April 18, 1995				3. TIME OF DEATH 5:30 a m	
4. SOCIAL SECURITY NUMBER 216-30-4528		5. SEX 1 <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 61 YRS.	7. DATE OF BIRTH (Month, Day, Year) Jan. 21, 1934	8. BIRTHPLACE (State or Foreign Country) Laurel, Md.				
9a. FACILITY NAME (If not Institution, give street and number) 9233 Grant Avenue				9b. CITY, TOWN OR LOCATION OF DEATH Laurel			9c. COUNTY OF DEATH Howard		
RESIDENCE OF DECEDENT									
10a. STATE Maryland		10b. COUNTY Howard		10c. CITY, TOWN OR LOCATION Laurel			10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
10e. STREET AND NUMBER 9233 Grant Avenue				10f. ZIP CODE 20723		10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 3 <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) 10			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Highway Technician			16b. KIND OF BUSINESS/INDUSTRY State Highway Administration			
17. FATHER'S NAME (First, Middle, Last) Gilbert R. Souder				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Edna Redmiles					
19a. INFORMANT'S NAME (Type/Print) Tammy Merson				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 408 Maiden Choice Lane Catonsville, Md. 21228					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify):		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Meadowridge Memorial Park			20c. LOCATION — City or Town, State Dorsey, Maryland				
21. SIGNATURE OF FUNERAL HOME LICENSEE Gregg S. R...				22. NAME AND ADDRESS OF FACILITY Donaldson Funeral Home P.A. 313 Talbott Ave. Laurel, Md. 20707					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Septicemia Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { Metastatic Carcinoma PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Esophageal stricture Diabetic Mellitus								Approximate Interval Between Onset and Death Days Weeks	
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER William A. Warren				29c. LICENSE NUMBER 013906		29d. DATE SIGNED (Month, Day, Year) 4/18/95			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) William A. Warren 321 Prince George St Laurel 20707									
31. DATE FILED (Month, Day, Year) APR 27 1995				32. REGISTRAR'S SIGNATURE Julia Davidson Randall					

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within _____ hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

95 13635

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Mary E. Spurrier</i>				2. DATE OF DEATH MONTH <i>APRIL</i> DAY <i>24</i> YEAR <i>1995</i>		3. TIME OF DEATH <i>1500</i> M	
4. SOCIAL SECURITY NUMBER <i>217-48-7247</i>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <i>84</i> YRS.	7. DATE OF BIRTH (Month, Day, Year) <i>July 1, 1910</i>		8. BIRTHPLACE (State or Foreign Country) <i>Maryland</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Lorien Nursing Home</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Columbia</i>		9c. COUNTY OF DEATH <i>Howard</i>	
10a. STATE <i>Maryland</i>		10b. COUNTY <i>Howard</i>		10c. CITY, TOWN OR LOCATION <i>Ellicott City</i>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <i>9080-C Town & Country</i>				10f. ZIP CODE <i>21043</i>		10g. CITIZEN OF WHAT COUNTRY? <i>United States</i>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>8</i> College (1-4 or 5+) <i></i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Homemaker</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Own Home</i>			
17. FATHER'S NAME (First, Middle, Last) <i>John R. Sullens</i>				16. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Anna Beck</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Marilyn Blake</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>4786 Beechwood Road Ellicott City, Maryland 21043</i>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>New Cathedral</i>		DATE <i>Apr 28</i>		20c. LOCATION — City or Town, State <i>Baltimore, Maryland</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Stanley M. Lowner</i>				22. NAME AND ADDRESS OF FACILITY <i>Harry H Witzke Funeral Home Inc 4112 Old Columbia Pike Ellicott City 21043</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Urinary sepsis</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. <i></i>							Approximate interval Between Onset and Death <i>1 Day</i>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Colon Cancer</i>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>GGM Proctor</i>				29c. LICENSE NUMBER <i>022547</i>		29d. DATE SIGNED (Month, Day, Year) <i>4/24/95</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Harry Little Patient G/M G/M, Maryland</i>							
31. DATE FILED (Month, Day, Year) <i>APR 27 1995</i>		32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13636

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) CAROLE ANNE SONGER				2. DATE OF DEATH MONTH DAY YEAR APRIL 19 1995		3. TIME OF DEATH 5:06 A M	
4. SOCIAL SECURITY NUMBER 215-44-6195		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 47 YRS.		7. DATE OF BIRTH (Month, Day, Year) Sept. 19, 1946	
9a. FACILITY NAME (If not institution, give street and number) SOUTHERN MARYLAND HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH CLINTON		9c. COUNTY OF DEATH PRINCE GEORGES	
10a. STATE MARYLAND		10b. COUNTY PRINCE GEORGES		10c. CITY, TOWN OR LOCATION CHELTENHAM		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 10316 ANGORA DRIVE				10f. ZIP CODE 20623		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Supervisor		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Supervisor		16b. KIND OF BUSINESS/INDUSTRY Bulk Mail			
17. FATHER'S NAME (First, Middle, Last) Howard Nicholas Lednum				18. MOTHER'S NAME (First, Middle, Maiden Surname) Jeannette Claire Walker			
19a. INFORMANT'S NAME (Type/Print) William E. Songer				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10316 Angora Drive, Cheltenham, MD 20623			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Trinity Memorial Gardens 4-22		20c. LOCATION — City or Town, State Waldorf, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Mark G. Brohawn M00053				22. NAME AND ADDRESS OF FACILITY Huntt Funeral Home P. O. Box 156, Waldorf, MD 20604-0156			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Mesenteric Artery graft occlusion / Artery occlusion Approximate Interval Between Onset and Death 6 months							
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
b. Bowel Necrosis DUE TO (OR AS A CONSEQUENCE OF):							
c. Hypertension DUE TO (OR AS A CONSEQUENCE OF):							
d. Metabolic Alkalosis DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. SIP Splenectomy							
24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Robert L. Davison MD				29c. LICENSE NUMBER 040479		29d. DATE SIGNED (Month, Day, Year) 04/19/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Robert L. Davison Jr MD 700 OLD LINE CTR #101 WALDORF MD 20602							
31. DATE FILED (Month, Day, Year) APR 20 1995				32. REGISTRAR'S SIGNATURE Julia Davidson Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13637

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JOHN DAVID STRAW SR.				2. DATE OF DEATH MONTH DAY YEAR April 9, 1995		3. TIME OF DEATH 2:50 P M	
4. SOCIAL SECURITY NUMBER 214-05-5035		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 84 YRS.		7. DATE OF BIRTH (Month, Day, Year) NOV 27 1910	
9a. FACILITY NAME (If not institution, give street and number) MEMORIAL HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH CUMBERLAND		9c. COUNTY OF DEATH ALLEGANY	
10a. STATE MARYLAND		10b. COUNTY ALLEGANY		10c. CITY, TOWN OR LOCATION CUMBERLAND		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 1005 HARDING AVENUE				10f. ZIP CODE 21502		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES U.S. NAVY WWII		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+) 		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) ASSISTANT ENGINEER FIREMAN		15b. KIND OF BUSINESS/INDUSTRY QUEEN CITY BREWERY			
17. FATHER'S NAME (First, Middle, Last) BRUCE P. STRAW				18. MOTHER'S NAME (First, Middle, Maiden Surname) MARY E. MONTGOMERY			
19a. INFORMANT'S NAME (Type/Print) RONALD J. STRAW				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12907 CRONES LANE NE CUMBERLAND MARYLAND 21502			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) HILLCREST CEMETERY APRIL 12, 1995		20c. LOCATION — City or Town, State CUMBERLAND MARYLAND		20d. DATE APRIL 12, 1995	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Dale L. Merritt</i>				22. NAME AND ADDRESS OF FACILITY MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
a. Renal cysts DUE TO (OR AS A CONSEQUENCE OF):							5 years
b. Sepsis DUE TO (OR AS A CONSEQUENCE OF):							1 week
c. Pyelonephritis DUE TO (OR AS A CONSEQUENCE OF):							1 week
d. 							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Vik Poonai</i>				29c. LICENSE NUMBER D 36766		29d. DATE SIGNED (Month, Day, Year) April 13, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Vik Poonai, 955 Frederick Street., Cumberland, MD 21502							
31. DATE FILED (Month, Day, Year) APR 13 1995				32. REGISTRAR'S SIGNATURE <i>John A. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13638

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) PAUL A. SALKELD				2. DATE OF DEATH MONTH APRIL DAY 4 YEAR 1995		3. TIME OF DEATH 12:57P M	
4. SOCIAL SECURITY NUMBER 231-18-4535		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 71 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 20 1923	
8. BIRTHPLACE (State or Foreign Country) Penna Fulton co				9. FACILITY NAME (If not institution, give street and number) Memorial Hospital of Cumberland			
10. CITY, TOWN OR LOCATION OF DEATH Cumberland				11. COUNTY OF DEATH Allegany			
12. RESIDENCE OF DECEDENT				13. CITY, TOWN OR LOCATION OF DEATH			
14. STATE Penna		15. COUNTY Bedford		16. CITY, TOWN OR LOCATION Breezewood		17. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
18. STREET AND NUMBER RD 1 Box 54A				19. ZIP CODE 15533		20. CITIZEN OF WHAT COUNTRY? usa	
21. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		22. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII		23. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		24. RACE — American Indian, Black, White, etc. Specify: white	
25. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		26. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) heavy equipment operator		27. KIND OF BUSINESS/INDUSTRY construction			
28. FATHER'S NAME (First, Middle, Last) lloyd E. Salkeld				29. MOTHER'S NAME (First, Middle, Maiden Surname) Bessie Spade			
30. INFORMANT'S NAME (Type/Print) Mrs. Bonnie Fetter				31. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) RD 1 Box 288a Osterburg, Pa, 16667			
32. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		33. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Mt. Zion Cemetery, Breezewood		34. DATE 4/7/95		35. LOCATION — City or Town, State Breezewood, Pa, 15533	
36. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				37. NAME AND ADDRESS OF FACILITY Dalla Valle FS inc po box 179 everett pa, 15537			
38. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Non small cell lung cancer DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
39. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
40. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		41. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
42. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		43. DATE OF INJURY (Month, Day, Year)		44. TIME OF INJURY M		45. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
46. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				47. DESCRIBE HOW INJURY OCCURRED			
48. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		49. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> MD		50. LICENSE NUMBER D43497		51. DATE SIGNED (Month, Day, Year) APRIL 4 1995	
52. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. DANIEL LEIBMAN, MEMORIAL HOSPITAL, SUITE 400, CUMBERLAND, MD 21502							
53. DATE FILED (Month, Day, Year) APR 12 1995		54. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13639

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) Creed George Smith				2. DATE OF DEATH MONTH 10 DAY 1995 YEAR		3. TIME OF DEATH 7:08PM M	
4. SOCIAL SECURITY NUMBER 214-07-6639		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 78 YRS.		7. DATE OF BIRTH MONTH 08 DAY 19 YEAR 1916	
9a. FACILITY NAME (If not institution, give street and number) 331 Dorn Ave.		9b. CITY, TOWN OR LOCATION OF DEATH Cumberland				9c. COUNTY OF DEATH Allegany	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY ALLEGANY		10c. CITY, TOWN OR LOCATION CUMBERLAND		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 331 DORN AVE.				10f. ZIP CODE 21502		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII US ARMY		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) OWNER OPERATOR SMITH ZEITH TV INC. TV SALES & SERVICE		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) JOHN HENRY SMITH				18. MOTHER'S NAME (First, Middle, Maiden Surname) BESSIE ELIZABETH SMITH			
19a. INFORMANT'S NAME (Type/Print) VICKIE DIAZ				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14306 N. BEL AIR DRIVE S.W. CUMBERLAND MARYLAND			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) SUNSET CEMETERY APRIL 14 1995		OATE		20c. LOCATION — City or Town, State CUMBERLAND MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Dale L. Merritt				22. NAME AND ADDRESS OF FACILITY MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (First disease or condition resulting in death) → a. Arteriosclerotic heart disease DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death 12 yrs
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicides 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Dpt Med Ex				29c. LICENSE NUMBER D 09157		29d. DATE SIGNED (Month, Day, Year) April 10 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Paul Snow, M.D. 124 w3rd st Cumb Md 21502							
31. DATE FILED (Month, Day, Year) APR 12 1995				32. REGISTRAR'S SIGNATURE John Marshall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

26

95 13640

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Richard Henry Thomas				2. DATE OF DEATH MONTH DAY YEAR 04 08 1995		3. TIME OF DEATH 0640 M	
4. SOCIAL SECURITY NUMBER 159-16-6351		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 80 YRS.		7. DATE OF BIRTH (Month, Day, Year) 12/17/1914	
8. BIRTHPLACE (State or Foreign Country) Pennsylvania				9a. FACILITY NAME (If not institution, give street and number) 31080 College Backbone Road		9b. CITY, TOWN OR LOCATION OF DEATH Princess Anne	
9c. COUNTY OF DEATH Somerset				10a. STATE Maryland		10b. COUNTY Somerset	
10c. CITY, TOWN OR LOCATION Princess Anne				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 31080 College Backbone Road	
10f. ZIP CODE 21853				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: Black				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6+ College (1-4 or 5+) retired -educator			
16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) University/College				17. FATHER'S NAME (First, Middle, Last) Isaac Thomas			
18. MOTHER'S NAME (First, Middle, Maiden Surname) Nana Aldridge				19a. INFORMANT'S NAME (Type/Print) Claudia Thomas			
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) same as above				20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) Entombment			
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Springhill Mausoleum 4/14				20c. LOCATION — City or Town, State Hebron, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Patricia A. Jolley</i>				22. NAME AND ADDRESS OF FACILITY 1213 Jersey Road - Salisbury Jolley Memorial Chapels - Maryland, 21801			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Respiratory Failure Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. neurovascular degeneration c. 15 yrs d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Nomicide 8 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>C. Jolley</i>				29c. LICENSE NUMBER 025219		29d. DATE SIGNED (Month, Day, Year) 4-12-95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) PRINCESS ANNE FAMILY PRACTICE 30434 MT. VERNON ROAD PRINCESS ANNE, MD 21853							
31. DATE FILED (Month, Day, Year) APR 13 1995							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95-2371-031

blh

ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-723 5/19/95 t.t

95 13641

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Laura Nadine Thomas				2. DATE OF DEATH MONTH DAY YEAR April 23 1995		3. TIME OF DEATH 0254	
4. SOCIAL SECURITY NUMBER 219-20-4113		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 66 YRS.		7. DATE OF BIRTH (Month, Day, Year) Feb. 10, 1929	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) Holy Cross Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring	
9c. COUNTY OF DEATH Montgomery				10a. STATE Maryland		10b. COUNTY Montgomery	
10c. CITY, TOWN OR LOCATION Silver Spring				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 10309 Conover Dr.	
10f. ZIP CODE 20902				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) 2				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) homemaker service		16b. KIND OF BUSINESS/INDUSTRY state government	
17. FATHER'S NAME (First, Middle, Last) Francis Brooks				18. MOTHER'S NAME (First, Middle, Maiden Surname) Hilda Rebecca Willis			
19a. INFORMANT'S NAME (Type/Print) E. Maxine Thomas				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10309 Conover Dr. Silver Spring, MD 20902			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Mt. Joy Cemetery 4/27		20c. LOCATION — City or Town, State Uniontown, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Catherine O. Sauter</i>				22. NAME AND ADDRESS OF FACILITY D.D. Hartzler & Sons Union Bridge, MD			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → SMOKE AND SOOT INHALATION, THERMAL INJURIES DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 4/23/95		28b. TIME OF INJURY 2:00 A M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED SUBJECT IN HOUSE FIRE		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) HOME				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 10309 CONOVER DR., SILVER SPRING, MD.	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Donald G. Wright MD</i>				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) April 23 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DONALD G. WRIGHT MD 111 Penn Street, Baltimore, Maryland 21201							
31. DATE FILED (Month, Day, Year) APR 25 1995				32. REGISTRAR'S SIGNATURE <i>Jane D. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13642

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

April 23, 1995 1AM

1. DECEDENT'S NAME (First, Middle, Last) <i>Mark S Teter</i>				2. DATE OF DEATH MONTH <i>April</i> DAY <i>23</i> YEAR <i>1995</i>		3. TIME OF DEATH <i>1:00 A M</i>	
4. SOCIAL SECURITY NUMBER <i>444-54-0073</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>40</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>Feb 3 1955</i>	
8. FACILITY NAME (If not institution, give street and number) <i>Anne Arundel Medical Center</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Annapolis</i>		9c. COUNTY OF DEATH <i>Anne Arundel</i>	
10a. STATE <i>MD</i>				10b. COUNTY <i>Anne Arundel</i>		10c. CITY, TOWN OR LOCATION <i>Annapolis</i>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <i>431 State Street</i>			
10f. ZIP CODE <i>21403</i>				10g. CITIZEN OF WHAT COUNTRY? <i>United States</i>			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>8</i> College (1-4 or 5+) <i>8</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Medical Doctor</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Rheumatologist</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Floyd A. Teter</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Billie Scott</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Floyd & Billie Teter</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>3012 East 93rd Ct. Tulsa, Oklahoma 74137</i>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>F.L. Lincoln Crematory 4/25/95</i>		20c. LOCATION — City or Town, State <i>Brentwood, Maryland</i>		21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Donald S. Lytle</i>	
22. NAME AND ADDRESS OF FACILITY <i>John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD</i>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Pneumonia</i>							
DUE TO (OR AS A CONSEQUENCE OF):							
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
b. <i>Human Immunodeficiency virus infection</i>							
DUE TO (OR AS A CONSEQUENCE OF):							
c. <i>Human Immunodeficiency virus infection</i>							
DUE TO (OR AS A CONSEQUENCE OF):							
d. <i>Human Immunodeficiency virus infection</i>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>David C Barnes MD</i>				29c. LICENSE NUMBER <i>D32469</i>		29d. DATE SIGNED (Month, Day, Year) <i>April 23, 1995</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>DAVID C BARNES 900 Bestgate Road, Suite 300 Annapolis MD 21401</i>							
31. DATE FILED (Month, Day, Year) <i>APR 25 1995</i>				32. REGISTRAR'S SIGNATURE <i>John Andrew Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13643

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Charlotte M. Troyner</i>				2. DATE OF DEATH MONTH DAY YEAR <i>April 20, 1995</i>		3. TIME OF DEATH <i>3:20 pm</i>	
4. SOCIAL SECURITY NUMBER <i>198-32-4229</i>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>52</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>January 7, 1943</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>2606 Myrtle Ave.</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore</i>		9c. COUNTY OF DEATH <i>Baltimore Co.</i>	
10a. STATE <i>MD</i>		10b. COUNTY <i>Carroll</i>		10c. CITY, TOWN OR LOCATION <i>Westminster</i>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <i>647 Cherrytown Rd.</i>				10f. ZIP CODE <i>21158</i>		10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i></i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Housework</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Housewife</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Elmer Walters</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Genevieve Burton</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Michael Troyner</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>15426 Arbory Way Laurel, MD 20707</i>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>St. Mary's Cemetery</i>		20c. LOCATION — City or Town, State <i>4/24 Silver Run, MD</i>		20d. DATE <i>4/24</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Richard Little Jr.</i>				22. NAME AND ADDRESS OF FACILITY <i>Littles' F.H. 34 Maple Ave. Littlestown, PA 17340</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Recurrent Endometrial Cancer</i> a. DUE TO (OR AS A CONSEQUENCE OF): <i>Cardiorespiratory Arrest</i> b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate interval between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. DESCRIBE NOW INJURY OCCURRED			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Francis Grantham</i>				29c. LICENSE NUMBER <i>220637</i>		29d. DATE SIGNED (Month, Day, Year) <i>4/24/95</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Francis Grantham / 666 N. Charles St. Sinter 1</i>							
31. DATE FILED (Month, Day, Year) <i>APR 21 1995</i>				32. REGISTRAR'S SIGNATURE <i>Johanna...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Earline TAYLOR				2. DATE OF DEATH MONTH April DAY 7 YEAR 1995		3. TIME OF DEATH 9:24 P. M	
4. SOCIAL SECURITY NUMBER 091-34-6472		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 51 YRS.		7. DATE OF BIRTH (Month, Day, Year) Aug. 02, 1943	
8. BIRTHPLACE (State or Foreign Country) Gambrells, MD.				9a. FACILITY NAME (If not institution, give street and number) Doctors Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Lanham, MD.	
9c. COUNTY OF DEATH P.G. County				10a. STATE MD.		10b. COUNTY P.G.	
10c. CITY, TOWN OR LOCATION Seabrook, MD.				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 6415 97th Avenue	
10f. ZIP CODE 20706				10g. CITIZEN OF WHAT COUNTRY? U. S. A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: Black				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11th College (1-4 or 5+) College			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Domestic				16b. KIND OF BUSINESS/INDUSTRY Maintenance			
17. FATHER'S NAME (First, Middle, Last) Charles D. Johnson				18. MOTHER'S NAME (First, Middle, Maiden Surname) Doris Smith			
19a. INFORMANT'S NAME (Type/Print) Doris Johnson				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6415 97th Ave., Seabrook, MD. 20706			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Harmony Memorial Park 4/14/95 Landover, MD.			
20c. LOCATION — City or Town, State				21. SIGNATURE OF FUNERAL SERVICE LICENSEE James E. Vann			
22. NAME AND ADDRESS OF FACILITY 4804 Ga. Ave., NW Washington, D.C. 20011				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → HEROIN OVERDOSE DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. HEROIN OVERDOSE DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input checked="" type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year) 4-6-95			
28b. TIME OF INJURY UNKNOWN				28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
28d. DESCRIBE HOW INJURY OCCURRED UNKNOWN				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) HOME			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) SAME AS #10				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER Dr. Aryanat				29c. LICENSE NUMBER D15558			
29d. DATE SIGNED (Month, Day, Year) 4/8/95				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) S.C. ARYANAT, MD, 3308 PERRY ST, MT. RAINIER, MD			
31. DATE FILED (Month, Day, Year) APR 11 1995				32. REGISTRAR'S SIGNATURE J. L. Anderson-Rodriguez			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13645

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) THEODORE THOERIG				2. DATE OF DEATH MONTH APRIL DAY 13 YEAR 1995				3. TIME OF DEATH 0157AM M			
4. SOCIAL SECURITY NUMBER 214-07-3576		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	8. AGE (In yrs. last birthday) 81 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) July 5, 1913		8. BIRTHPLACE (State or Foreign Country) MARYLAND	
9a. FACILITY NAME (If not institution, give street and number) MEMORIAL HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH CUMBERLAND				9c. COUNTY OF DEATH ALLEGANY			
10a. STATE MARYLAND		10b. COUNTY ALLEGANY		10c. CITY, TOWN OR LOCATION MT. SAVAGE				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER BRUCE HOUSE FARM				10f. ZIP CODE 21545				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATAS W.W.II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: WHITE			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) LAW ENFORCEMENT OFFICER-				16b. KIND OF BUSINESS/INDUSTRY DEPARTMENT OF NATURAL RESOURCES			
17. FATHER'S NAME (First, Middle, Last) WILLIAM FRANKLIN THOERIG				18. MOTHER'S NAME (First, Middle, Maiden Surname) HARRIETT ANN JENKINS							
19a. INFORMANT'S NAME (Type/Print) PHYLLIS THOERIG				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. BOX 532 - MT. SAVAGE, MD 21545							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MSVC-ROCKY GAP 4/17/95				20c. LOCATION — City or Town, State FLINTSTONE, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Sherry G. Upchurch</i>				22. NAME AND ADDRESS OF FACILITY GEORGE-UPCHURCH FUNERAL HOME, P.A. 202 GREENE ST., CUMBERLAND, MD 21502							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cerebrovascular Disease DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DCA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Homicide 4 <input type="checkbox"/>				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. W. Guy Fiscus</i>				29c. LICENSE NUMBER 012799				29d. DATE SIGNED (Month, Day, Year) April 15, 1995			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. W. GUY FISCUS MEMORIAL HOSPITAL MEDICAL BLDG., 500 MEMORIAL AVE., CUMBERLAND, MD 21502											
31. DATE FILED (Month, Day, Year) APR 17 1995				32. REGISTRAR'S SIGNATURE <i>John R. Randall</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



3 1/2 NOTION

Amended #4, 4/17/95, N.D.S., Allegany Co.

95 13646

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) WILLIAM DALE THOMPSON				2. DATE OF DEATH MONTH APRIL DAY 14 YEAR 1995		3. TIME OF DEATH 7:00 A M			
4. SOCIAL SECURITY NUMBER 235-20-2190		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 69 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0	IF UNDER 24 HRS. HOURS 0 MIN. 0	7. DATE OF BIRTH (Month, Day, Year) Sept. 8, 1925		8. BIRTHPLACE (State or Foreign Country) West Virginia	
9a. FACILITY NAME (If not institution, give street and number) SACRED HEART HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH CUMBERLAND			9c. COUNTY OF DEATH ALLEGANY		
RESIDENCE OF DECEDENT									
10a. STATE West Va		10b. COUNTY Mineral		10c. CITY, TOWN OR LOCATION Ridgeley			10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
10e. STREET AND NUMBER Route 1, Box 482				10f. ZIP CODE 26753		10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT, EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES W.W.II & Korea		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+) 2		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Storekeeper			16b. KIND OF BUSINESS/INDUSTRY P.P.G.				
17. FATHER'S NAME (First, Middle, Last) Samuel thompson				18. MOTHER'S NAME (First, Middle, Maiden Surname) Rose McMillen					
19a. INFORMANT'S NAME (Type/Print) Kay M. Thompson				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Route 1, Box 482 -Ridgeley, WV 26753					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Hillcrest Burial Park 4/17/95			20c. LOCATION — City or Town, State Cumberland, MD				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Wanda N. Ischance</i>				22. NAME AND ADDRESS OF FACILITY George-Upchurch Funeral Home, P.A. 202 Greene St., Cumberland, MD 21502					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Respiratory Arrest DUE TO (OR AS A CONSEQUENCE OF): b. Acute Pneumonia DUE TO (OR AS A CONSEQUENCE OF): c. Endstage NonHodgkins Lymphoma DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death 5 min 24 hrs 2 yrs	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Gary Wagoner</i>				29c. LICENSE NUMBER D22181		29d. DATE SIGNED (Month, Day, Year) APRIL 14, 1995			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) GARY WAGONER, M.D. 925 BISHOP WALSH ROAD CUMBERLAND, MD. 21502									
31. DATE FILED (Month, Day, Year) APR 17 1995		32. REGISTRAR'S SIGNATURE <i>John R. Randall</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 13647

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Mary Alice THOMPSON				2. DATE OF DEATH MONTH April DAY 23 YEAR 1995		3. TIME OF DEATH 6:50 A. M	
4. SOCIAL SECURITY NUMBER 220-74-6480		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 67 YRS.		7. DATE OF BIRTH (Month, Day, Year) Dec. 18, 1927	
9a. FACILITY NAME (If not institution, give street and number) Citizens Nursing Home				9b. CITY, TOWN OR LOCATION OF DEATH Frederick		9c. COUNTY OF DEATH Frederick	
10a. STATE Maryland				10b. COUNTY Frederick		10c. CITY, TOWN OR LOCATION Union Bridge	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 9001 Dolly Hyde Road			
10f. ZIP CODE 21791				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No - If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE - American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Home			
17. FATHER'S NAME (First, Middle, Last) Charles E. MURPHY				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mamie E. WARFIELD			
19a. INFORMANT'S NAME (Type/Print) Mr. Richard C. Thompson, Jr.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9001 Dolly Hyde Road, Union Bridge, MD 21791			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Mount Olivet Cemetery, Apr. 25, 1995 Frederick, Maryland		20c. LOCATION - City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Alan H Ruby MC0703				22. NAME AND ADDRESS OF FACILITY Keeney & Basford P.a. Funeral Home 106 East Church St., Frederick, MD 21701			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pneumonia DUE TO (OR AS A CONSEQUENCE OF): b. Alzheimer's Disease DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Undetermined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED		28e. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Gene F. Ashe				29c. LICENSE NUMBER 03105P		29d. DATE SIGNED (Month, Day, Year) 4/24/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Gene F. Ashe, M.D., 10200 Coopermine Road, Woodsboro, MD 21798							
31. DATE FILED (Month, Day, Year) APR 24 1995				32. REGISTRAR'S SIGNATURE John Anderson Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13648

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) INGEBORG T. TYLER				2. DATE OF DEATH APRIL 18, 1995		3. TIME OF DEATH 5:10 P M	
4. SOCIAL SECURITY NUMBER 575-36-6689		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 63 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 25, 1931	
8. BIRTHPLACE (State or Foreign Country) Germany		9a. FACILITY NAME (If not institution, give street and number) 63 GARNER AVENUE (RESIDENCE)		9b. CITY, TOWN OR LOCATION OF DEATH WALDORF		9c. COUNTY OF DEATH CHARLES	
10a. STATE Maryland		10b. COUNTY Charles		10c. CITY, TOWN OR LOCATION Waldorf		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 63 Garner Avenue		10f. ZIP CODE 20602		10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 8		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife		16b. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) unknown				18. MOTHER'S NAME (First, Middle, Maiden Surname) Aplonia Goebauer			
19a. INFORMANT'S NAME (Type/Print) William F. Tyler				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 63 Garner Avenue, Waldorf, MD 20602			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Maryland Veterans' Cem. 4-21		20c. LOCATION — City or Town, State Cheltenham, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Benjamin M. Matthews M00658				22. NAME AND ADDRESS OF FACILITY Huntt Funeral Home, Inc. Waldorf, MD 20604			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CANCER OF OVARY DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death 2 yr
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURRED					
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Krishan Mathur				29c. LICENSE NUMBER D-28352		29d. DATE SIGNED (Month, Day, Year) 4-19-95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Krishan Mathur, MD. 11340 Pembroke Square Suite 213, Waldorf, Maryland 20603							
31. DATE FILED (Month, Day, Year) APR 20 1995				32. REGISTRAR'S SIGNATURE Julia Shuster Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13649

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Nicholas George Valltos, Sr.				2. DATE OF DEATH MONTH DAY YEAR April 8, 1995		3. TIME OF DEATH 10:42 P M	
4. SOCIAL SECURITY NUMBER 579-20-3964		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 70 YRS.		7. DATE OF BIRTH (Month, Day, Year) Nov. 29, 1924	
9a. FACILITY NAME (If not institution, give street and number) Prince George's Hospital Center				9b. CITY, TOWN OR LOCATION OF DEATH Cheverly		9c. COUNTY OF DEATH Prince George's	
10a. STATE Maryland		10b. COUNTY Prince George's		10c. CITY, TOWN OR LOCATION Upper Marlboro		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 413 Kettering Drive				10f. ZIP CODE 20772		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Restaurant Owner		16b. KIND OF BUSINESS/INDUSTRY Restaurant			
17. FATHER'S NAME (First, Middle, Last) George Anatious				18. MOTHER'S NAME (First, Middle, Maiden Surname) Valchiliki Ofanos			
19a. INFORMANT'S NAME (Type/Print) Mary E. Valltos				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 413 Kettering Dr. Upper Marlboro, Md. 20772			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Maryland Veterans Cemetery		DATE 4/13/95		20c. LOCATION — City or Town, State Cheltenham, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>George P. Kalas</i>				22. NAME AND ADDRESS OF FACILITY George P. Kalas Funeral Home 6160 Oxon Hill Rd. Oxon Hill, Md. 20745			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Arteriosclerotic cardiovascular disease</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DDA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Augusto P. Rodriguez MD</i>				29c. LICENSE NUMBER D21230		29d. DATE SIGNED (Month, Day, Year) April 9, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Augusto P. Rodriguez MD, 5009 Rayburn Ct. C, Jr. Md 20748</i>							
31. DATE FILED (Month, Day, Year) APR 10 1995				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Virginia J. Windsor</i>				2. DATE OF DEATH MONTH <i>APR</i> DAY <i>22</i> YEAR <i>95</i>				3. TIME OF DEATH <i>7:50 P.M.</i>					
4. SOCIAL SECURITY NUMBER <i>217-05-8030</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <i>76</i> YRS.	IF UNDER 1 YEAR MONTHS _____ DAYS _____		IF UNDER 24 HRS. HOURS _____ MIN. _____		7. DATE OF BIRTH (Month, Day, Year) <i>Mar 14 1919</i>		8. BIRTHPLACE (State or Foreign Country) <i>Maryland</i>			
9a. FACILITY NAME (If not institution, give street and number) <i>Dorchester General Hospital</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Cambridge</i>				9c. COUNTY OF DEATH <i>Dorchester</i>					
RESIDENCE OF DECEDENT													
10a. STATE <i>Maryland</i>		10b. COUNTY <i>Dorchester</i>		10c. CITY, TOWN OR LOCATION <i>Cambridge</i>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
10e. STREET AND NUMBER <i>909 Roslyn Ave.</i>				10f. ZIP CODE <i>21613</i>				10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <i>white</i>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>10</i> College (1-4 or 5+) _____				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>homemaker</i>				16b. KIND OF BUSINESS/INDUSTRY					
17. FATHER'S NAME (First, Middle, Last) <i>Sherman Robinson</i>						18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Lizzie Jones</i>							
19a. INFORMANT'S NAME (Type/Print) <i>Mrs. Phyllis Walker</i>						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>413 Bayly Ave., Cambridge MD 21613</i>							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Dorchester Memorial Park 4/25 Cambridge Md.</i>				20c. LOCATION — City or Town, State					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Kenneth R. Thomas Jr.</i>						22. NAME AND ADDRESS OF FACILITY <i>Thomas Funeral Home 700 Locust St. Cambridge MD 21613</i>							
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</i> Approximate Interval Between Onset and Death <i>5-6 yrs.</i> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):										24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.													
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <i>D1566 +</i>		29d. DATE SIGNED (Month, Day, Year) <i>4/23/95</i>					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>M-S. SCHARFF, M.D. 105 Aurora St., Cambridge MD 21613</i>													
31. DATE FILED (Month, Day, Year) <i>APR 24 1995</i>				32. REGISTRAR'S SIGNATURE <i>Johanna Randall</i>									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13651

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Jeanne Winterbottom Wright				2. DATE OF DEATH MONTH: April DAY: 22, YEAR: 1995				3. TIME OF DEATH 1:00 A M	
4. SOCIAL SECURITY NUMBER 220-46-1460		5. SEX 1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 79 YRS.	IF UNDER 1 YEAR MONTHS: DAYS: HOURS: MIN.		7. DATE OF BIRTH (Month, Day, Year) April 23, 1915		8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not institution, give street and number) Dorchester General Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Cambridge				9c. COUNTY OF DEATH Dorchester	
RESIDENCE OF DECEDENT									
10a. STATE Maryland		10b. COUNTY Dorchester		10c. CITY, TOWN OR LOCATION Cambridge				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 115 Mill Street				10f. ZIP CODE 21613		10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) 5+				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker			16b. KIND OF BUSINESS/INDUSTRY		
17. FATHER'S NAME (First, Middle, Last) W. Grason Winterbottom				18. MOTHER'S NAME (First, Middle, Maiden Surname) Nannie Davis					
19a. INFORMANT'S NAME (Type/Print) Hubert H. Wright IV				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 110 Cambridge, Maryland 21613					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Christ Episcopal Churchyard 4/25		20c. LOCATION — City or Town, State Cambridge, Md.					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY Thomas Funeral Home 700 Locust St. Cambridge, Maryland 21613					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Acute Renal Failure DUE TO (OR AS A CONSEQUENCE OF): Congestive Heart Failure DUE TO (OR AS A CONSEQUENCE OF): C. Difficile Colitis DUE TO (OR AS A CONSEQUENCE OF): Chronic Obstructive Pulmonary Disease Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Basal Cell Carcinoma PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
24a. WAS AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO									
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO									
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER Judge C. Washington, MD				29c. LICENSE NUMBER D31108		29d. DATE SIGNED (Month, Day, Year) 4/22/95			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 21) (Type/Print) Judge C. Washington, MD 408 Bynn Street Cambridge MD 21613									
31. DATE FILED (Month, Day, Year) APR 24 1995				32. REGISTRAR'S SIGNATURE Julia Stueber Randall					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13652

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH4-18-95 9:36AM
REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Julius Napoleon Woods				2. DATE OF DEATH MONTH 4 DAY 18 YEAR 95		3. TIME OF DEATH 0936	
4. SOCIAL SECURITY NUMBER 403-16-9867		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 77 YRS.		7. DATE OF BIRTH (Month, Day, Year) 7/29/17	
8. FACILITY NAME (If not institution, give street and number) 29 West Washington St.				9. CITY, TOWN OR LOCATION OF DEATH Annapolis		10. COUNTY OF DEATH AA	
11. STATE MD		12. COUNTY Anne Arundel		13. CITY, TOWN OR LOCATION Annapolis		14. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
15. STREET AND NUMBER 29 West Washington Street				16. ZIP CODE 21401		17. CITIZEN OF WHAT COUNTRY? United States	
18. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		19. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		20. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		21. RACE — American Indian, Black, White, etc. Specify: White	
22. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College		23. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Contractor		24. KIND OF BUSINESS/INDUSTRY Ship Builder			
25. FATHER'S NAME (First, Middle, Last) unknown				26. MOTHER'S NAME (First, Middle, Maiden Surname) unknown			
27. INFORMANT'S NAME (Type/Print) Karl C. Wehr				28. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 52 Gentry Court Annapolis, MD 21403			
29. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		30. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Cedar Bluff Cemetery 4/25/95		31. DATE 4/25/95		32. LOCATION — City or Town, State Annapolis, Maryland	
33. SIGNATURE OF FUNERAL SERVICE LICENSEE [Signature]				34. NAME AND ADDRESS OF FACILITY John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD			
35. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → ASCVD DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. ASCVD DUE TO (OR AS A CONSEQUENCE OF): b. _____ DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____							
36. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____ _____ _____							
37. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>				38. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		39. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
40. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		41. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
42. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		43. DATE OF INJURY (Month, Day, Year)		44. TIME OF INJURY M		45. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
46. DESCRIBE HOW INJURY OCCURRED				47. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
48. LOCATION (Street and Number or Rural Route Number, City or Town, State)				49. DATE SIGNED (Month, Day, Year) 4/18/95			
50. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
51. SIGNATURE AND TITLE OF CERTIFIER William R. Jones Deputy				52. LICENSE NUMBER D06054		53. DATE SIGNED (Month, Day, Year) 4/18/95	
54. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) William R. Jones, M.D. 695 America Ct 21035							
55. DATE FILED (Month, Day, Year) APR 25 1995				56. REGISTRAR'S SIGNATURE [Signature]			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13653

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) James Samuel Walker Sr.				2. DATE OF DEATH MONTH 4 DAY 19 YEAR 95		3. TIME OF DEATH 1050 M	
4. SOCIAL SECURITY NUMBER 219-22-3803		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 67 YRS.		7. DATE OF BIRTH (Month, Day, Year) 5/13/27	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) 1401 Cape St. Clair Rd.		9b. CITY, TOWN OR LOCATION OF DEATH Annapolis	
9c. COUNTY OF DEATH AA				10a. STATE Maryland		10b. COUNTY Anne Arundel	
10c. CITY, TOWN OR LOCATION Annapolis				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. ZIP CODE 21401	
10f. CITIZEN OF WHAT COUNTRY? U.S.A.				11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE YEAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: Caucasian			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12+ College (1-4 or 5+) Ret. Carpenter				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Construction			
17. FATHER'S NAME (First, Middle, Last) Holland Walker				18. MOTHER'S NAME (First, Middle, Maiden Surname) Lillian Walker			
19a. INFORMANT'S NAME (Type/Print) Mr. James S. Walker, Jr.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20 Hilltop Ln. Annapolis, MD 21403			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Cedar Hill Cemetery 4-24-1995 Brooklyn, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James E. Barlow</i>				22. NAME AND ADDRESS OF FACILITY Barranco & Sons Funeral Home 21146 495 Ritchie Hwy Severna Park, MD			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → ASCVD DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>William P. Jones Deputy</i>				29c. LICENSE NUMBER DO6054		29d. DATE SIGNED (Month, Day, Year) 4/20/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) William P. Jones MD 695 America 21035							
31. DATE FILED (Month, Day, Year) APR 27 1995				32. REGISTRAR'S SIGNATURE <i>John Andrew Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13654

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Connie Willett</i>				2. DATE OF DEATH MONTH DAY YEAR <i>April 21, 1995</i>		3. TIME OF DEATH <i>5:25 PM</i>	
4. SOCIAL SECURITY NUMBER 400-56-2977		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 54 YRS.		7. DATE OF BIRTH (Month, Day, Year) April 20, 1941	
8. BIRTHPLACE (State or Foreign Country) Kentucky				9a. FACILITY NAME (If not institution, give street and number) Fort Washington Medical Center		9b. CITY, TOWN OR LOCATION OF DEATH Fort Washington	
9c. COUNTY OF DEATH Prince George				10a. STATE Maryland			
10b. COUNTY Charles		10c. CITY, TOWN OR LOCATION Indian Head		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Her Home		17. FATHER'S NAME (First, Middle, Last) Earl Alery Shupe	
18. MOTHER'S NAME (First, Middle, Maiden Surname) Minnie Ann Swafford		19a. INFORMANT'S NAME (Type/Print) Charles Donald Willett		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as #10		20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Lee Funeral Home April 23, 1995		20c. LOCATION — City or Town, State Clinton, Maryland		21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Wesley Williams</i> M00668		22. NAME AND ADDRESS OF FACILITY Williams Funeral Home, P.A. Rt. 225 & Glymont Rd, Indian Head, Md.	
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Diabetic hyperosmolar nonketotic coma</i> DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, tectory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Augusto P. Rodriguez MD</i>		29c. LICENSE NUMBER A21230		29d. DATE SIGNED (Month, Day, Year) April 22, 1995		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Augusto P. Rodriguez MD, 5009 Rayburn Ct, Sp. Md 20748	
31. DATE FILED (Month, Day, Year) APR 26 1995		32. REGISTRAR'S SIGNATURE <i>Julia Duckworth Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13655

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Robert Darrell Whittaker				2. DATE OF DEATH MONTH April DAY 7 YEAR 1995		3. TIME OF DEATH 8:15P M	
4. SOCIAL SECURITY NUMBER 315-54-1436		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 45 YRS.		7. DATE OF BIRTH (Month, Day, Year) Nov. 27, 1949	
8. BIRTHPLACE (State or Foreign Country) Indiana				9a. FACILITY NAME (If not institution, give street and number) 5012 Manor Court		9b. CITY, TOWN OR LOCATION OF DEATH Oxon Hill	
9c. COUNTY OF DEATH Prince George's				10a. STATE Maryland		10b. COUNTY Prince George's	
10c. CITY, TOWN OR LOCATION Oxon Hill				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 5012 Manor Court	
10f. ZIP CODE 20745				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2 Years College (1-4 or 5+) 2 Years				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Minister		16b. KIND OF BUSINESS/INDUSTRY Private	
17. FATHER'S NAME (First, Middle, Last) Robert Earl Whittaker				18. MOTHER'S NAME (First, Middle, Maiden Surname) Edith E. Berry			
19a. INFORMANT'S NAME (Type/Print) Sandra Whittaker/Wife				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5012 Manor Court Oxon Hill, Maryland 20745			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Harmony Memorial Park		20c. LOCATION — City or Town, State 4-15 Landover, Maryland		20d. DATE 4-15	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Mawana L Braxton</i>				22. NAME AND ADDRESS OF FACILITY J.B. Jenkins Funeral Home 7474 Landover Road, Landover, MD 20785			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Acquired Immune Deficiency Syndrome DUE TO (OR AS A CONSEQUENCE OF): Mal nutrition Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Venkat Mani</i>				29c. LICENSE NUMBER D16390		29d. DATE SIGNED (Month, Day, Year) 4/10/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Venkat Mani, M.D. 8926 Woodlawn Rd #503 Clinton MD 20735							
31. DATE FILED (Month, Day, Year) APR 11 1995				32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 13656

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JAMES BERNARD WHITFIELD				2. DATE OF DEATH MONTH APRIL DAY 7 YEAR 1995		3. TIME OF DEATH 11:30 A.M.	
4. SOCIAL SECURITY NUMBER 578-46-7470		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 61 YRS.		7. DATE OF BIRTH (Month, Day, Year) DEC. 27, 1933	
9a. FACILITY NAME (If not institution, give street and number) 112 ESSENTON DRIVE				9b. CITY, TOWN OR LOCATION OF DEATH UPPER MARLBORO		9c. COUNTY OF DEATH PRINCE GEORGES	
10a. STATE MARYLAND		10b. COUNTY PRINCE GEORGE'S		10c. CITY, TOWN OR LOCATION UPPER MARLBORO		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 112 ESSENTON DRIVE				10f. ZIP CODE 20772		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES AIR FORCE - 20 YEARS		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4 YEARS		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) MASTER MECHANIC		16b. KIND OF BUSINESS/INDUSTRY (GOVT.) US POSTAL SERVICE			
17. FATHER'S NAME (First, Middle, Last) JOHN WHITFIELD				18. MOTHER'S NAME (First, Middle, Maiden Surname) LILLIE MAE GRISWALD			
19a. INFORMANT'S NAME (Type/Print) PATRICIA WHITFIELD/ WIFE				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 112 ESSENTON DRIVE UPPER MARLBORO, MD 20772			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) ARLINGTON NATIONAL CEM. 4-13		20c. LOCATION — City or Town, State ARLINGTON, VIRGINIA		20d. DATE 4-13	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Juanana J. Braxton</i>				22. NAME AND ADDRESS OF FACILITY J.B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MD 20785			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ACUTE MYOCARDIAL INFARCTION DUE TO (OR AS A CONSEQUENCE OF): b. CORONARY HEART DISEASE DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Approximate Interval Between Onset and Death MINUTES YEARS							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE NOW INJURY OCCURRED					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>J. Berger MD</i>		29c. LICENSE NUMBER D25925		29d. DATE SIGNED (Month, Day, Year) Apr 7, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J. BERGER MD #205, 7720 WISCONSIN AVE Bethesda MD 20814							
31. DATE FILED (Month, Day, Year) APR 11 1995		32. REGISTRAR'S SIGNATURE <i>J. Berger</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13657

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Patrick J. Wenzel				2. DATE OF DEATH MONTH DAY YEAR April 8, 1995				3. TIME OF DEATH 7:20 p.m.					
4. SOCIAL SECURITY NUMBER 218-09-9474		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 77 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) March 17, 1918		8. BIRTHPLACE (State or Foreign Country) Washington, D.C.	
9a. FACILITY NAME (If not institution, give street and number) 8501 48th Avenue						9b. CITY, TOWN OR LOCATION OF DEATH College Park				9c. COUNTY OF DEATH Prince George's			
RESIDENCE OF DECEDENT													
10a. STATE Maryland		10b. COUNTY Prince George's		10c. CITY, TOWN OR LOCATION College Park				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO					
10e. STREET AND NUMBER 8501 48th Avenue				10f. ZIP CODE 20740				10g. CITIZEN OF WHAT COUNTRY? U.S.A.					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) 10				18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Carpenter				18b. KIND OF BUSINESS/INDUSTRY Private					
17. FATHER'S NAME (First, Middle, Last) Joseph Wenzel						18. MOTHER'S NAME (First, Middle, Maiden Surname) Catherine Schatz							
19a. INFORMANT'S NAME (Type/Print) John F. Wenzel						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13510 Rt. 108, Highland, Maryland 20777							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) George Washington Cem. 4/13/95				20c. LOCATION — City or Town, State Adelphi, Maryland					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Charles F. Bell						22. NAME AND ADDRESS OF FACILITY Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → MALIGNANT CARDIAC ARRHYTHMIA Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. CONGESTIVE CARDIOMYOPATHY c. DUE TO (OR AS A CONSEQUENCE OF): d.												Approximate Interval Between Onset and Death 1 year 8 years	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.													
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER Asif Qadri						29c. LICENSE NUMBER D22910		29d. DATE SIGNED (Month, Day, Year) APRIL 10, 1995					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Asif Qadri, M.D. 4700 Berwyn House Road, #100, College Park, MD 20740													
31. DATE FILED (Month, Day, Year) APR 14 1995				32. REGISTRAR'S SIGNATURE Julia A. Anderson-Richard									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

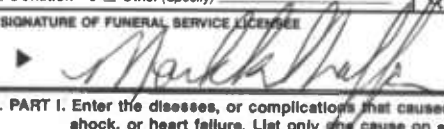
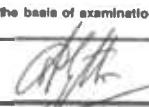

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13658

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) VIVIAN THEODOSIA WEBB				2. DATE OF DEATH MONTH DAY YEAR April 15, 1995		3. TIME OF DEATH 9:46 P M	
4. SOCIAL SECURITY NUMBER 234-44-7013		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 82 YRS.		7. DATE OF BIRTH (Month, Day, Year) March 27, 1913	
9a. FACILITY NAME (If not institution, give street and number) Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Cumberland		9c. COUNTY OF DEATH Allegany	
10a. STATE WV				10b. COUNTY Hampshire		10c. CITY, TOWN OR LOCATION Romney	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 665 Fourth Street			
10f. ZIP CODE 26757				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College		15a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		15b. KIND OF BUSINESS/INDUSTRY Home			
17. FATHER'S NAME (First, Middle, Last) Clarence E. Wood				18. MOTHER'S NAME (First, Middle, Maiden Surname) Lillian Bosley			
19a. INFORMANT'S NAME (Type/Print) Mary Ann Liller				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 638 1st St., Romney, WV 26757			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Queen's Point Cemetery, March 18, 1995		20c. LOCATION — City or Town, State Keyser, WV		20d. DATE March 18, 1995	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Shaffer Funeral Home, Inc. Romney, WV 26757			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. Sepsis				Approximate Interval Between Onset and Death 24 Hours	
		b. Gangrene of both Legs				48 Hours	
		c. Saddle Embolism				48 Hours	
		d.					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Pending Investigation 3 <input type="checkbox"/> Accident 4 <input type="checkbox"/> Suicide 5 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER  Dr. Ranjithan				29c. LICENSE NUMBER D 19318		29d. DATE SIGNED (Month, Day, Year) April 17, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Ranjithan, 517 Oldtown Road, Cumberland, MD 21502							
31. DATE FILED (Month, Day, Year) APR 20 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13659

1. FOR *Statistics*
STATE REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MILDRED CROSBY WALTER				2. DATE OF DEATH MONTH Apr DAY 15 YEAR 1995		3. TIME OF DEATH 8:30 A M	
4. SOCIAL SECURITY NUMBER 212-20-1310		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 80 YRS.		7. DATE OF BIRTH (Month, Day, Year) Sep 13, 1914	
9a. FACILITY NAME (If not institution, give street and number) FROSTBURG VILLAGE NURSING HOME				9b. CITY, TOWN OR LOCATION OF DEATH FROSTBURG		9c. COUNTY OF DEATH ALLEGANY	
10a. STATE MD		10b. COUNTY Frederick		10c. CITY, TOWN OR LOCATION Frederick		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 200 E. 16th Street				10f. ZIP CODE 21701		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) homemaker		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) homemaker		15b. KIND OF BUSINESS/INDUSTRY own home			
17. FATHER'S NAME (First, Middle, Last) William Grogan				18. MOTHER'S NAME (First, Middle, Maiden Surname) Willie Jarrell			
19a. INFORMANT'S NAME (Type/Print) George E. Walter				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12124 Marigold Avenue; Cumberland, MD 21502			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Smithsburg Crematorium		20c. LOCATION — City or Town, State 04/18 Smithsburg, MD		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James F. Scarpelli</i>				22. NAME AND ADDRESS OF FACILITY Scarpelli Funeral Home Cumberland, MD 21502			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF): Sequently ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. Coronary Artery Disease DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death 30 min. 10 years
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Mellitus Arteriosclerotic Vascular Disease DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>S. Chang M.D.</i>				29c. LICENSE NUMBER D25638		29d. DATE SIGNED (Month, Day, Year) April 19 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Saturnina Chang, M.D. Rt 36 Frostburg Plaza Frostburg, MD 21532							
31. DATE FILED (Month, Day, Year) APR 19 1995							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13660

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Thelma F. Wilson				2. DATE OF DEATH MONTH DAY YEAR April 22, 1995		3. TIME OF DEATH 12:00 M	
4. SOCIAL SECURITY NUMBER 235-36-4863 A		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 90 YRS.		7. DATE OF BIRTH (Month, Day, Year) Feb. 19, 1905	
9a. FACILITY NAME (If not institution, give street and number) 18 Georgetown Road		9b. CITY, TOWN OR LOCATION OF DEATH Walkersville		9c. COUNTY OF DEATH Frederick			
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Frederick		10c. CITY, TOWN OR LOCATION Walkersville		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 18 Georgetown Road				10f. ZIP CODE 21793		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+)		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Waitress		15b. KIND OF BUSINESS/INDUSTRY Food Service			
17. FATHER'S NAME (First, Middle, Last) Charles B. Writesel				16. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Frances			
19a. INFORMANT'S NAME (Type/Print) Frances J. Starkey				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18 Georgetown Road Walkersville, MD 21793			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Floral Hills Memory Garden 4/26/95		20c. LOCATION — City or Town, State Chillicothe, Ohio		DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike Frederick, MD 21702			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>SQUAMOUS CANCER NECK</u> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death 4 yrs							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>COPD</u> <u>HTN</u> DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D 32171		29d. DATE SIGNED (Month, Day, Year) 4/24/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Richard Gough, M.D. 19 Frederick Road Walkersville, Maryland 21793							
31. DATE FILED (Month, Day, Year) APR 24 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 5 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13661

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Ruth Isabelle WILLIAMS				2. DATE OF DEATH MONTH DAY YEAR April 20 1995		3. TIME OF DEATH 4:10 pm	
4. SOCIAL SECURITY NUMBER 219-20-3238		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 85 YRS.		7. DATE OF BIRTH (Month, Day, Year) Feb 7, 1910	
8. BIRTHPLACE (State or Foreign Country) Maryland							
9a. FACILITY NAME (If not institution, give street and number) Meridian Nursing Center				9b. CITY, TOWN OR LOCATION OF DEATH Frederick		9c. COUNTY OF DEATH Frederick	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Frederick		10c. CITY, TOWN OR LOCATION Ijamsville		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 9545 Fingerboard Road				10f. ZIP CODE 21754		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (8-12) 12				15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Waitress		15b. KIND OF BUSINESS/INDUSTRY Restaurant	
17. FATHER'S NAME (First, Middle, Last) John Henry THOMPSON				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ora SMITH			
19a. INFORMANT'S NAME (Type/Print) Mary Ann Thornton				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 603 West Patrick Street, Frederick, Maryland 21701			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Ebenezer UM Cemetery April 25, 1995		20c. LOCATION — City or Town, State Centreville, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY C.E. Hicks III Funeral Service 1922 Forest Drive, Annapolis, MD 21401			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → CVA.							
DUE TO (OR AS A CONSEQUENCE OF):							
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
DUE TO (OR AS A CONSEQUENCE OF):							
DUE TO (OR AS A CONSEQUENCE OF):							
DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D13971		29d. DATE SIGNED (Month, Day, Year) 4/24/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Robert L. Kaufmann, M.D., 300 West Ninth Street, Frederick, Maryland 21701							
31. DATE FILED (Month, Day, Year) APR 24 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13662

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Latha Alma Webb				2. DATE OF DEATH MONTH April DAY 18, YEAR 1995		3. TIME OF DEATH 9:45 p M	
4. SOCIAL SECURITY NUMBER 217-30-5669		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 80 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Sept. 11, 1914	
8. BIRTHPLACE (State or Foreign Country) West Virginia				9a. FACILITY NAME (If not institution, give street and number) Frederick Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Frederick	
9c. COUNTY OF DEATH Frederick				10a. STATE Maryland		10b. COUNTY Frederick	
10c. CITY, TOWN OR LOCATION Frederick				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 2733 Thurston Rd.	
10f. ZIP CODE 21701				10g. CITIZEN OF WHAT COUNTRY? United States		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) -				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home	
17. FATHER'S NAME (First, Middle, Last) Russell Clark Reed				18. MOTHER'S NAME (First, Middle, Maiden Surname) Leona Josephine Lilly			
19a. INFORMANT'S NAME (Type/Print) Donald R. Webb, Sr.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2739 Thurston Rd./ Frederick, Md. 21701			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Resthaven memorial		20c. LOCATION — City or Town, State 4-21 Frederick, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Raymond Peterson</i>				22. NAME AND ADDRESS OF FACILITY Stauffer Funeral Home 1621 Opossumtown Pike/Frederick, Md. 21702			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CEREBRAL CONTUSION DUE TO (OR AS A CONSEQUENCE OF): b. FALL & HEAD INJURY DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate interval Between Onset and Death 2 days 2 days Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ① Hip FRACTURE 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year) 7/16/95		28b. TIME OF INJURY 3:00 P M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED FALL			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) Home				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 2733 THURSTON RD. FREDERICK MD 21701			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Robert R R Roberts</i>				29c. LICENSE NUMBER D09867		29d. DATE SIGNED (Month, Day, Year) APRIL 21 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) RRR ROBERTS MD 15 W 7TH ST FREDERICK MD 21701-4599							
31. DATE FILED (Month, Day, Year) MAY 09 1995				32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed without delay after death. Page 6 may be retained by the hospital or attending physician.



TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13663

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) LAUREL Genevieve YEARGAIN				2. DATE OF DEATH MONTH DAY YEAR APRIL 24, 1995		3. TIME OF DEATH HOURS MIN. 02:00 M		
4. SOCIAL SECURITY NUMBER 215-43-0366		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) YRS. MONTHS DAYS 6 0		7. DATE OF BIRTH (Month, Day, Year) 10-24-1994		
9a. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY		9c. COUNTY OF DEATH		
10a. STATE MD		10b. COUNTY Harford		10c. CITY, TOWN OR LOCATION Abingdon		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		
10e. STREET AND NUMBER 117-G Waldon Road				10f. ZIP CODE 21009		10g. CITIZEN OF WHAT COUNTRY? USA		
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 0 College (1-4 or 5+) College				18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) None		18b. KIND OF BUSINESS/INDUSTRY		
17. FATHER'S NAME (First, Middle, Last) James Douglas Yeargain				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Pamela Topper				
19a. INFORMANT'S NAME (Type/Print) M/M James D. Yeargain				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 117-G Waldon Road, Abingdon, MD 21009				
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Mt. Erin Cemetery		DATE 4/28		20c. LOCATION — City or Town, State Havre de Grace, MD		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Mitchell-Smith Funeral Home, P.A. Havre de Grace, MD 21078-3197				
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sepsis							Approximate Interval Between Onset and Death 24 Hours	
a. DUE TO (OR AS A CONSEQUENCE OF): Liver Failure (Cholestatic Jaundice)								
b. DUE TO (OR AS A CONSEQUENCE OF): Total Parenteral Nutrition dependent								
c. DUE TO (OR AS A CONSEQUENCE OF): Megacystic Microcolon Hypoperistaltic Syndrome								
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Anemia, Thrombocytopenia							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>								
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) N.A.		28b. TIME OF INJURY N.A.		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) N.A.		28e. DESCRIBE HOW INJURY OCCURRED N.A.		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) N.A.		
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. SIGNATURE AND TITLE OF CERTIFIER James J. Tehr / PICU Physician				29c. LICENSE NUMBER 61923 Maryland		29d. DATE SIGNED (Month, Day, Year) 4/24/95		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) James J. Tehr MD								
31. DATE FILED (Month, Day, Year) APR 26 1995				32. REGISTRAR'S SIGNATURE 				

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

W. J. H. H. H.

1917 11 13 1910

95 13664

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Mollie Elzora YOUNG				2. DATE OF DEATH MONTH April DAY 21 YEAR 1995		3. TIME OF DEATH 12:05 pm	
4. SOCIAL SECURITY NUMBER 214-10-4316		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 88 YRS.		7. DATE OF BIRTH (Month, Day, Year) Mar 30, 1907	
8. BIRTHPLACE (State or Foreign Country) Washington DC				9a. FACILITY NAME (If not institution, give street and number) Northampton Manor Nursing Center		9b. CITY, TOWN OR LOCATION OF DEATH Frederick	
9c. COUNTY OF DEATH Frederick				10a. STATE Maryland		10b. COUNTY Frederick	
10c. CITY, TOWN OR LOCATION Frederick				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 701 Wyngate Drive	
10f. ZIP CODE 21701				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: White				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+) College			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Owned/Operated				16b. KIND OF BUSINESS/INDUSTRY Restaurant			
17. FATHER'S NAME (First, Middle, Last) William WADFORD				18. MOTHER'S NAME (First, Middle, Maiden Surname) Grace WHIPP			
19a. INFORMANT'S NAME (Type/Print) Mrs. Ruth M. Gilbert				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6814 Blentlinger Road, Frederick, Maryland 21702			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Linden Hills Cemetery Apr 24, 1995 Frederick, Maryland			
20c. LOCATION — City or Town, State				21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Keith Lynum Roberson</i> M00706			
22. NAME AND ADDRESS OF FACILITY Keeney & Basford P.A. Funeral Home 106 East Church Street, Frederick, MD 21701				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Atherosclerosis Disease</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. c. d. Approximate Interval Between Onset and Death 7 yrs			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY M 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 28d. DESCRIBE HOW INJURY OCCURRED 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>Philip J. Shapiro</i>			
29c. LICENSE NUMBER D07186				29d. DATE SIGNED (Month, Day, Year) 4/24/95			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Philip J. Shapiro, M.D., 814 Tollhouse Avenue, Frederick, Maryland 21701				31. DATE FILED (Month, Day, Year) APR 24 1995			
32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

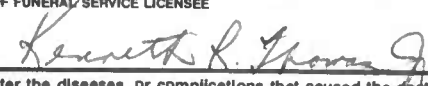

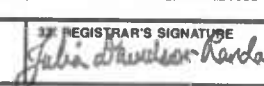
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13665

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) HENRY STUART ZIMMERMAN				2. DATE OF DEATH MONTH April DAY 26 YEAR 1995		3. TIME OF DEATH 9:00 a. M	
4. SOCIAL SECURITY NUMBER 216-07-9584		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 92 YRS.	7. DATE OF BIRTH (Month, Day, Year) Aug. 23 1902		8. BIRTHPLACE (State or Foreign Country) Pennsylvania	
9a. FACILITY NAME (If not institution, give street and number) Dorchester General Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Cambridge		9c. COUNTY OF DEATH Dorchester	
10a. STATE Maryland				10b. COUNTY Dorchester		10c. CITY, TOWN OR LOCATION Cambridge	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 6 Algonquin Rd.		10f. ZIP CODE 21613	
10g. CITIZEN OF WHAT COUNTRY? U.S.A.				11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: white		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) accountant				16b. KIND OF BUSINESS/INDUSTRY automobile dealership		17. FATHER'S NAME (First, Middle, Last) William K. Zimmerman	
18. MOTHER'S NAME (First, Middle, Maiden Surname) Alta (unknown)				19a. INFORMANT'S NAME (Type/Print) Mrs. Bernice Zimmerman		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6 Algonquin Rd. Cambridge MD 21613	
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Dorchester Memorial Park 4/28		20c. LOCATION — City or Town, State Cambridge Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Thomas Funeral Home 700 Locust St. Cambridge MD 21613			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Acute Anterior Wall Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF): Arteriosclerosis Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): Arteriosclerotic Cardiovascular disease with Atrial fibrillation							Approximate interval Between Onset and Death 3 days
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Arteriosclerotic Cardiovascular disease with Atrial fibrillation							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D 14349		29d. DATE SIGNED (Month, Day, Year) April 26, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Eyup Tanman, M.D. 15 Franklin St., Cambridge MD 21613							
31. DATE FILED (Month, Day, Year) APR 27 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13666

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Nellie E. Zeigler				2. DATE OF DEATH MONTH DAY YEAR April 19, 1995		3. TIME OF DEATH 9:45 a m	
4. SOCIAL SECURITY NUMBER 212-38-7613		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 57 YRS.	7. DATE OF BIRTH (Month, Day, Year) Nov 23, 1937		8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not institution, give street and number) Meridian Health Care Center at Aspenwood				9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring		9c. COUNTY OF DEATH Montgomery	
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Gaithersburg		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 8 West Deer Park Drive - Apt 103				10f. ZIP CODE 20877		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Bus Aide		16b. KIND OF BUSINESS/INDUSTRY Montgomery County School System			
17. FATHER'S NAME (First, Middle, Last) Charles T. Zeigler, Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Allie E. Dorsey			
19a. INFORMANT'S NAME (Type/Print) Joyce E. Zeigler				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5743 Sunset View Lane, Frederick, Maryland			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Pleasant Grove Cemetery 4/22		20c. LOCATION — City or Town, State Damascus, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Don L. Williams</i>				22. NAME AND ADDRESS OF FACILITY Olin L. Molesworth, P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Breast Cancer</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>Bilateral Leg Edema</u> DUE TO (OR AS A CONSEQUENCE OF): c. <u>Metastatic Breast Cancer</u> DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death 1-2 yrs							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>G. Thaker</i>				29c. LICENSE NUMBER D43430		29d. DATE SIGNED (Month, Day, Year) 4/20/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Gaurang Thaker M.D. 18111 Prince Philip Dr. Olney, Md							
31. DATE FILED (Month, Day, Year) APR 24 1995				32. REGISTRAR'S SIGNATURE <i>Juba Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13667

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) BABY GIRL				2. DATE OF DEATH MONTH DAY YEAR APRIL 10, 1995				3. TIME OF DEATH 03:20 A M	
4. SOCIAL SECURITY NUMBER		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) YRS. MONTHS DAYS ALLEN		7. DATE OF BIRTH (Month, Day, Year) April 6, 1995		8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY				9c. COUNTY OF DEATH	
10a. STATE Maryland		10b. COUNTY		10c. CITY, TOWN OR LOCATION				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER				10f. ZIP CODE		10g. CITIZEN OF WHAT COUNTRY?			
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) James Allen				18. MOTHER'S NAME (First, Middle, Maiden Surname) Patricia A. Allen					
19a. INFORMANT'S NAME (Type/Print) Patricia A. Allen				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 811 East 41st Street, Baltimore, Maryland 21218					
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) The Johns Hopkins Hospital		OATE 4/10/95		20c. LOCATION — City or Town, State Baltimore, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ► The Johns Hopkins Hospital				22. NAME AND ADDRESS OF FACILITY 600 North Wolfe Street, Baltimore, Maryland					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → CONGENITAL HEART DISEASE - CARDIOMYOPATHY DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death 4 days	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER Maria A. Pane MD							
29c. LICENSE NUMBER M 1960		29d. DATE SIGNED (Month, Day, Year) 4/10/95							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JOHNS HOPKINS HOSPITAL, BALTIMORE, MD. (MARIA A. PANE MD)									
31. DATE FILED (Month, Day, Year) MAY 05 1995		32. REGISTRAR'S SIGNATURE John A. Anderson-Randall							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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NOTES

95 13668

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Boy P Andritz				2. DATE OF DEATH MONTH April DAY 22 YEAR 95				3. TIME OF DEATH 8:12A M	
4. SOCIAL SECURITY NUMBER 099-16-8993		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 74 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) July 12, 1920	
8. BIRTHPLACE (State or Foreign Country) Buffalo, NY				9a. FACILITY NAME (If not institution, give street and number) Charles Co. Nursing Home				9b. CITY, TOWN OR LOCATION OF DEATH LaPlata	
9c. COUNTY OF DEATH Charles				10a. STATE MD				10b. COUNTY Charles	
10c. CITY, TOWN OR LOCATION Newburg				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 8919 Emerald Lane	
10f. ZIP CODE 20664				10g. CITIZEN OF WHAT COUNTRY? U.S.A.				11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO If YES, GIVE YEAR OR DATES WW II				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Maintenance Supervisor				16b. KIND OF BUSINESS/INDUSTRY Municipal Government	
17. FATHER'S NAME (First, Middle, Last) Fred J. Andritz				18. MOTHER'S NAME (First, Middle, Maiden Surname) Sarah Driggs Andritz				19a. INFORMANT'S NAME (Type/Print) T. Dottie Andritz	
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8919 Emerald Lane Newburg, MD 20664				20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of place, date, city or town, state) Metropolitan Cre. April 23, 1995 Alexandria, VA	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE David C. Echols MO0945				22. NAME AND ADDRESS OF FACILITY AREHART-ECHOLS FUNERAL HOME, INC. P.O. Box 567 LaPlata, MD 20646				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sudden cardiac death Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Atherosclerotic Cardiovascular Disease Hypertension	
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)	
28b. TIME OF INJURY M				28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
29b. SIGNATURE AND TITLE OF CERTIFIER [Signature]				29c. LICENSE NUMBER				29d. DATE SIGNED (Month, Day, Year) 4/22/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)				31. DATE FILED (Month, Day, Year) APR 24 1995				32. REGISTRAR'S SIGNATURE [Signature]	

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Mary G. Actis				2. DATE OF DEATH MONTH DAY YEAR April 13, 1995				3. TIME OF DEATH 7:35 am	
4. SOCIAL SECURITY NUMBER 229-27-8883		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 67 YRS.		7. DATE OF BIRTH MONTH DAY YEAR October 15, 1927		8. BIRTHPLACE (State or Foreign Country) Virginia	
9a. FACILITY NAME (If not institution, give street and number) Holy Cross Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring				9c. COUNTY OF DEATH Montgomery	
10a. STATE Maryland				10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Gaithersburg			
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 923 Clopper Road #A-4		10f. ZIP CODE 20878		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker				16b. KIND OF BUSINESS/INDUSTRY Own Home	
17. FATHER'S NAME (First, Middle, Last) Charles Edwards Burns				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ethel Louise Flora					
19a. INFORMANT'S NAME (Type/Print) Jewel Glisson				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 923 Clopper Road #A-4 Gaithersburg, Maryland 20878					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) DATE Woodlawn Memorial Gardens April 18, 1995				20c. LOCATION — City or Town, State Norfolk, Virginia	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>George J. [Signature]</i> M00335				22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → CARDIAC ARRHYTHMIA DUE TO (OR AS A CONSEQUENCE OF): CHRONIC OBSTRUCTIVE PULMONARY DISEASE DUE TO (OR AS A CONSEQUENCE OF): CHRONIC RENAL FAILURE DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. SMOKER								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO								DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Kathleen K. Davis M.D.</i>				29c. LICENSE NUMBER D37096				29d. DATE SIGNED (Month, Day, Year) April 13, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Kathleen K. Davis M.D. 8700 Georgia Avenue #400 Silver Spring, Maryland 20910-3605									
31. DATE FILED (Month, Day, Year) APR 17 1995				32. REGISTRAR'S SIGNATURE <i>Julia [Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JERRY DEAN AYERS				2. DATE OF DEATH MONTH April DAY 20 YEAR 1995		3. TIME OF DEATH 12:15 A.M.	
4. SOCIAL SECURITY NUMBER 215-52-6577		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 46 YRS.		7. DATE OF BIRTH (Month, Day, Year) AUG. 10, 1948	
9a. FACILITY NAME (If not institution, give street and number) SHADY GROVE ADVENTIST HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH ROCKVILLE		9c. COUNTY OF DEATH MONTGOMERY	
10a. STATE MD.		10b. COUNTY PRINCE GEORGES		10c. CITY, TOWN OR LOCATION BELTSVILLE		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 11362 CHERRY HILL RD.				10f. ZIP CODE 20705		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES VIETNAM		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CAB DRIVER		16b. KIND OF BUSINESS/INDUSTRY TRANSPORTATION	
17. FATHER'S NAME (First, Middle, Last) CALVIN F. AYERS				18. MOTHER'S NAME (First, Middle, Maiden Surname) DORIS CRABTREE			
19a. INFORMANT'S NAME (Type/Print) DORIS AYERS				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) SAME AS ITEM #10			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GEORGE WASHINGTON CEMETERY 4/24		20c. LOCATION — City or Town, State ADELPHI, MD.		20d. DATE 4/24	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>W.W. Chambers</i> M00091				22. NAME AND ADDRESS OF FACILITY W. W. CHAMBERS CO., RIVERDALE, MD. 20737			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiopulmonary arrest DUE TO (OR AS A CONSEQUENCE OF): b. Fulminant sepsis and DIC DUE TO (OR AS A CONSEQUENCE OF): c. Rt sided Pneumonia w/2 respiratory failure DUE TO (OR AS A CONSEQUENCE OF): d. Neutropenia and Anemia, Bronchopneumonia Approximate Interval Between Onset and Death minutes 24hrs.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Rakesh Vinayek M.D.</i>				29c. LICENSE NUMBER D32633		29d. DATE SIGNED (Month, Day, Year) APR 20 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) RAKESH VINAYEK 11570 Old Georgetown Rd. Rockville, MD 20852							
31. DATE FILED (Month, Day, Year) APR 21 1995				32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

241

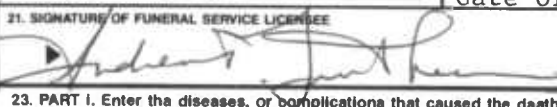
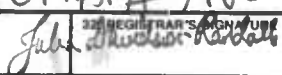
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 -
FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) REFUGIO SISTER MARIA REAUGIO ANGULO				2. DATE OF DEATH MONTH DAY YEAR April 18, 1995		3. TIME OF DEATH 4:45 P.M.	
4. SOCIAL SECURITY NUMBER 212-84-6438		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 53 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 1, 1941	
9a. FACILITY NAME (If not institution, give street and number) 19101 Georgia Avenue				9b. CITY, TOWN OR LOCATION OF DEATH Brookeville		9c. COUNTY OF DEATH Montgomery	
10a. STATE Maryland				10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Brookeville	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER 19101 Georgia Avenue, P.O. Box 220			
10f. ZIP CODE 20883				10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO Specify: Spanish		14. RACE — American Indian, Black, White, etc. Specify: Spanish	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		15a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Religious Woman		15b. KIND OF BUSINESS/INDUSTRY Roman Catholic Church			
17. FATHER'S NAME (First, Middle, Last) Gerardo Angulo				18. MOTHER'S NAME (First, Middle, Maiden Surname) Maria dela Luz Bravo			
19a. INFORMANT'S NAME (Type/Print) Sister Luz Castro				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19101 Georgia Ave., P.O. Box 220, Brookeville, MD			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gate of Heaven Cemetery 4/21		20c. LOCATION — City or Town, State Silver Spring, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Brain and Bone metastases DUE TO (OR AS A CONSEQUENCE OF): b. Carcinoma of the Breast DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death months 10 years							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURRED					
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER Israel Spector MD				29c. LICENSE NUMBER D11200		29d. DATE SIGNED (Month, Day, Year) 4/19/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 12001 Ferrara Ave Wheaton Md 20906							
31. DATE FILED (Month, Day, Year) APR 21 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13672

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) Albert Louis Andrew				2. DATE OF DEATH MONTH April DAY 14 YEAR 1995		3. TIME OF DEATH 3:15 A M	
4. SOCIAL SECURITY NUMBER 212-19-2113		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 38 YRS.		7. DATE OF BIRTH (Month, Day, Year) 5/15/56	
9a. FACILITY NAME (If not institution, give street and number) 7017 Mayfair Road				9b. CITY, TOWN OR LOCATION OF DEATH Laurel		9c. COUNTY OF DEATH Prince George	
RESIDENCE OF DECEASED							
10a. STATE MD		10b. COUNTY Prince George		10c. CITY, TOWN OR LOCATION Laurel		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 7017 Mayfair Road				10f. ZIP CODE 20707		10g. CITIZEN OF WHAT COUNTRY? Grenada	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR OATES		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Nursing Assistant		16b. KIND OF BUSINESS/INDUSTRY Health Care			
17. FATHER'S NAME (First, Middle, Last) Not Available				18. MOTHER'S NAME (First, Middle, Maiden Surname) Dorothy Andrew			
19a. INFORMANT'S NAME (Type/Print) Brenda Davis				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7017 Mayfair Road/Laurel/MD 20707			
20a. MANNER OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Maryland Nat'l Mem Park 4/14		20c. LOCATION — City or Town, State Laurel MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>M. Wilhelm Wagner</i>				22. NAME AND ADDRESS OF FACILITY Advent Memorial Services Annapolis MD 21401			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. complications of HIV DUE TO (OR AS A CONSEQUENCE OF): b. CNS Toxoplasmosis DUE TO (OR AS A CONSEQUENCE OF): c. Disseminated Mycobacterium Avium Intracellularis DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death 1 YR 2 mos
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CMV Disease Dehydration							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							29b. SIGNATURE AND TITLE OF CERTIFIER <i>R. Cox - J. D.</i>
29c. LICENSE NUMBER 19457 / D.C.						29d. DATE SIGNED (Month, Day, Year) 4/14/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 1701 14th St NW Washington D.C. 20009							
31. DATE FILED (Month, Day, Year) APR 20 1995				32. REGISTRAR'S SIGNATURE <i>Julia Davidson Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13673

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ABRON LEE Ayers				2. DATE OF DEATH MONTH April DAY 13 YEAR 1995		3. TIME OF DEATH 1525 M	
4. SOCIAL SECURITY NUMBER 225-76-5513		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 45 YRS.		7. DATE OF BIRTH (Month, Day, Year) 12-15-49	
9a. FACILITY NAME (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER		9b. CITY, TOWN OR LOCATION OF DEATH SALISBURY				9c. COUNTY OF DEATH WICOMICO	
RESIDENCE OF DECEDENT							
10a. STATE VA		10b. COUNTY ACCOMACK		10c. CITY, TOWN OR LOCATION PAINTER		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 17471 MAPPSBURG RD.				10f. ZIP CODE 23420		10g. CITIZEN OF WHAT COUNTRY? U.S.A	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) College		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) BARBER		15b. KIND OF BUSINESS/INDUSTRY BARBER			
17. FATHER'S NAME (First, Middle, Last) AARON AYERS				18. MOTHER'S NAME (First, Middle, Maiden Surname) MARGARET UPSHUR			
19a. INFORMANT'S NAME (Type/Print) FANNIE M. AYERS				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17471 Mappsburg Rd. Painter, Va. 23420			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MT. CALVARY CHURCH CEM. 4-20-95		20c. LOCATION — City or Town, State EXMORE, VA.		DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY GIDDENS FUNERAL HOME P.O. BOX 177 PAINTER, VA 23420			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
a. CARDIOPULMONARY ARREST FROM METASTATIC CA DUE TO (OR AS A CONSEQUENCE OF): b. METASTATIC SQUAMOUS CELL CARCINOMA OF DUE TO (OR AS A CONSEQUENCE OF): c. (P) TONSIL WITH LIVER & BONE INVOLVEMENT DUE TO (OR AS A CONSEQUENCE OF): d. ALSO CHRONIC ANEMIA							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHRONIC DISEASE ANEMIA							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURRED					
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D40516 MARYLAND		29d. DATE SIGNED (Month, Day, Year) 4/13/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MICHAEL J. KELLETER MD 106 MILFORD ST SALISBURY MD							
31. DATE FILED (Month, Day, Year) APR 17 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.


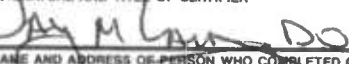
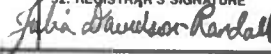
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13674

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Richard Nolan Allen				2. DATE OF DEATH MONTH DAY YEAR APR 18, 1995		3. TIME OF DEATH 4:00 P M	
4. SOCIAL SECURITY NUMBER 233-56-3586		5. SEX 1 <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 56 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 11-20-1938	
9a. FACILITY NAME (If not institution, give street and number) Harford Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Havre de Grace		9c. COUNTY OF DEATH Harford	
10a. STATE MD		10b. COUNTY Harford		10c. CITY, TOWN OR LOCATION Havre de Grace		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 1000 Morrison Blvd.				10f. ZIP CODE 21078		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Chief, Veterans Canteen Services		16b. KIND OF BUSINESS/INDUSTRY Federal Government - Veterans Hospital			
17. FATHER'S NAME (First, Middle, Last) Richard Harry Allen				18. MOTHER'S NAME (First, Middle, Maiden Surname) Clara Mae Wine			
19a. INFORMANT'S NAME (Type/Print) Mrs. Linda L. Allen				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1000 Morrison Blvd, Havre de Grace, MD 21078			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) R. A. Ferris & Co., Inc. 4/11		DATE 4/11		20c. LOCATION — City or Town, State West Chester, PA	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Mitchell-Smith Funeral Home, P.A. Havre de Grace, MD 21078-3197			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → ACUTE INFERIOR WALL MYOCARDIAL INFARCTION 3 HOURS DUE TO (OR AS A CONSEQUENCE OF): a. CORONARY ARTERY DISEASE 10 YRS DUE TO (OR AS A CONSEQUENCE OF): b. VENTRICULAR TACHYCARDIA 10 YRS DUE TO (OR AS A CONSEQUENCE OF): c. ATRIAL FIBRILLATION MONTHS DUE TO (OR AS A CONSEQUENCE OF): d. ATRIAL FIBRILLATION MONTHS							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. DESCRIBE NOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER  DO ATTENDING				29c. LICENSE NUMBER H44463		29d. DATE SIGNED (Month, Day, Year) 4/8/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JAY M. LANG, DO 658 BOULTON ST., BEL AIR MD 21014							
31. DATE FILED (Month, Day, Year) APR 12 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13675

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) SARAH ODESSA AMREIN				2. DATE OF DEATH MONTH DAY YEAR April 7, 1995		3. TIME OF DEATH 7:55 P M	
4. SOCIAL SECURITY NUMBER 213-74-9702		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 91 YRS.		7. DATE OF BIRTH (Month, Day, Year) 5/19/1903	
8. BIRTHPLACE (State or Foreign Country) Maryland							
9a. FACILITY NAME (If not institution, give street and number) 3955 Old Rocks Road				9b. CITY, TOWN OR LOCATION OF DEATH Street		9c. COUNTY OF DEATH Harford	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Harford		10c. CITY, TOWN OR LOCATION Street		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 3955 Old Rocks Road				10f. ZIP CODE 21154		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) --				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife		16b. KIND OF BUSINESS/INDUSTRY Home	
17. FATHER'S NAME (First, Middle, Last) William Neeper				18. MOTHER'S NAME (First, Middle, Maiden Surname) Sarah Ann Streett			
19a. INFORMANT'S NAME (Type/Print) Mary M. Amrein				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3955A Old Rocks Rd. Street, Md. 21154			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Bel Air Mem. Gardens		20c. LOCATION — City or Town, State 4/10 Bel Air, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>M. Hadden</i>				22. NAME AND ADDRESS OF FACILITY Kurtz Funeral Home Jarrettsville, Maryland			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → congestive heart failure DUE TO (OR AS A CONSEQUENCE OF): b. coronary artery disease DUE TO (OR AS A CONSEQUENCE OF): c. diabetes DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST						Approximate interval Between Onset and Death ~2y ~2y	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>David S. Dunn</i>				29c. LICENSE NUMBER D32299		29d. DATE SIGNED (Month, Day, Year) Apr 11, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) David S. Dunn Bel Air, Maryland							
31. DATE FILED (Month, Day, Year) APR 12 1995		32. REGISTRAR'S SIGNATURE <i>Jana Anderson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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95 13676

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Kermit Taylor Brooks				2. DATE OF DEATH MONTH DAY YEAR 04 22 95		3. TIME OF DEATH 16:40 p. M	
4. SOCIAL SECURITY NUMBER 218-03-6665		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 85 YRS.	7. DATE OF BIRTH (Month, Day, Year) 12/27/1909		8. BIRTHPLACE (State or Foreign Country) Virginia	
9a. FACILITY NAME (If not institution, give street and number) Garrett County Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Oakland		9c. COUNTY OF DEATH Garrett	
10a. STATE Maryland				10b. COUNTY Garrett		10c. CITY, TOWN OR LOCATION Kitzmilller	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 1185 Kitzmilller Road, Box 30,		10f. ZIP CODE 21538	
10g. CITIZEN OF WHAT COUNTRY? USA				11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 10				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Steel Maker		16b. KIND OF BUSINESS/INDUSTRY Bethlehem Steel	
17. FATHER'S NAME (First, Middle, Last) Boise Brooks				18. MOTHER'S NAME (First, Middle, Maiden Surname) Florie Brooks			
19a. INFORMANT'S NAME (Type/Print) Alverta Brooks				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1185 Kitzmilller Road, Box 30, Kitzmilller, MD 21538			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Kalbaugh Cemetery Apr 25, 95		20c. LOCATION — City or Town, State Elk Garden, WV	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE David A. Burdock				22. NAME AND ADDRESS OF FACILITY David A. Burdock Funeral Home P.O. Box 523, Kitzmilller, MD 21538			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. acute myocardial infarction DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. atherosclerotic cardiovascular disease DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death 5 minutes 1 month							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. congestive heart failure							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Walter K. Naumann M.D.				29c. LICENSE NUMBER D25759		29d. DATE SIGNED (Month, Day, Year) April 24, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Walter K. Naumann, M.D., PO Box 247, Accident MD 21520							
31. DATE FILED (Month, Day, Year) APR 24 1995				32. REGISTRAR'S SIGNATURE Julia Anderson-Rodriguez			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

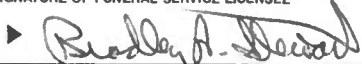
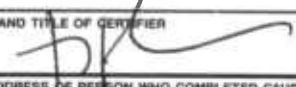
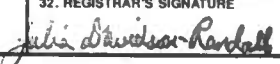
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13677

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Ruba Marie BROADWATER				2. DATE OF DEATH MONTH DAY YEAR April 9, 1995				3. TIME OF DEATH 7:45 P M			
4. SOCIAL SECURITY NUMBER 219-14-6238		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 71 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) Dec. 13, 1923		8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not institution, give street and number) Garrett County Memorial Hospital						9b. CITY, TOWN OR LOCATION OF DEATH Oakland			9c. COUNTY OF DEATH Garrett		
RESIDENCE OF DECEDENT											
10a. STATE MD		10b. COUNTY Garrett		10c. CITY, TOWN OR LOCATION Mt. Lake Park				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER 209 G Street				10f. ZIP CODE 21550				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Waitress				16b. KIND OF BUSINESS/INDUSTRY Restaurant			
17. FATHER'S NAME (First, Middle, Last) Irvin Roy Hare						18. MOTHER'S NAME (First, Middle, Maiden Surname) Bertha Victoria Broadwater					
19a. INFORMANT'S NAME (Type/Print) Carolyn E. Sanders						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17 E. Water St., Oakland, MD 21550					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Garrett Co. Mem. Gardens 4/12				20c. LOCATION — City or Town, State Oakland, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 						22. NAME AND ADDRESS OF FACILITY Stewart Funeral Home 32 S. Second St., Oakland, MD 21550					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cerebrovascular accident DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST } b. Diabetes mellitus c. Hypertension d. DUE TO (OR AS A CONSEQUENCE OF):											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.											
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO											
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO											
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER 						29c. LICENSE NUMBER D15333			29d. DATE SIGNED (Month, Day, Year) 4/10/95		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) Dr. Thomas Johnson, MD 311 N. Fourth St., Oakland, MD 21550											
31. DATE FILED (Month, Day, Year) APR 19 1995				32. REGISTRAR'S SIGNATURE 							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13678

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) GLADYS L. BOWMAN				2. DATE OF DEATH MONTH APRIL DAY 24 YEAR 1995		3. TIME OF DEATH 04:05 P M	
4. SOCIAL SECURITY NUMBER 172-40-6738		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 58 YRS.		7. DATE OF BIRTH (Month, Day, Year) Feb. 20, 1937	
9a. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY		9c. COUNTY OF DEATH Penna.	
RESIDENCE OF DECEDENT							
10a. STATE Pa.		10b. COUNTY York		10c. CITY, TOWN OR LOCATION Hallam Box Twp.		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER Rd12, Box 154				10f. ZIP CODE 17406		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) Charles -- Bowman				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary -- McGurk			
19a. INFORMANT'S NAME (Type/Print) Teena M. Beck				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4860 Hikey St., Dover, Pa. 17315			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Susquehanna Mem. Gards. 4/28/95		DATE York Twp., Pa.		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Guy M. Klinefelter M00679				22. NAME AND ADDRESS OF FACILITY Austin H. Eberly F.H. Inc. 104 W. Main St., Dallastown, Pa. 17313			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Left Ventricular aneurysm DUE TO (OR AS A CONSEQUENCE OF): b. Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF): c. Coronary artery disease DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death 5 weeks 2 years 3 years							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — A1 home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Arthur Coday Jr. M.D. Resident				29c. LICENSE NUMBER L9928		29d. DATE SIGNED (Month, Day, Year)	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Arthur Coday Jr. M.D. 600 North Wolfe Street, Baltimore, MD 21205							
31. DATE FILED (Month, Day, Year) MAY 03 1995				32. REGISTRAR'S SIGNATURE John Swanson			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Handwritten text, possibly a signature or date, located at the bottom center of the page.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				CERTIFICATE OF DEATH				REG. NO.			
1. DECEDENT'S NAME (First, Middle, Last) Albert Dean Bailey				2. DATE OF DEATH MONTH DAY YEAR April 22 1995				3. TIME OF DEATH 10:20 AM M							
4. SOCIAL SECURITY NUMBER 249-62-3573		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 62 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) June 13, 1932		8. BIRTHPLACE (State or Foreign Country) South Carolina			
9a. FACILITY NAME (If not institution, give street and number) 410 Breslin Road				9b. CITY, TOWN OR LOCATION OF DEATH Joppa				9c. COUNTY OF DEATH Harford							
10a. STATE Maryland		10b. COUNTY Harford		10c. CITY, TOWN OR LOCATION Joppa				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER 410 Breslin Road				10f. ZIP CODE 21085				10g. CITIZEN OF WHAT COUNTRY? USA							
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: white							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) 10				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) General Contractor				16b. KIND OF BUSINESS/INDUSTRY Construction							
17. FATHER'S NAME (First, Middle, Last) Elmo Baskin Bailey				18. MOTHER'S NAME (First, Middle, Maiden Surname) Lillie Cleo Barton											
19a. INFORMANT'S NAME (Type/Print) Diane A. Bailey				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 410 Breslin Road, Joppa, Maryland 21085											
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Holly Hill Cemetery 4/26/95		20c. LOCATION — City or Town, State Middle River, Maryland											
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Howard K. McComas III</i>				22. NAME AND ADDRESS OF FACILITY Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009											
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Non Hodykni lymphoma</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death 1 mos							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>															
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)													
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED							
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)											
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								29b. SIGNATURE AND TITLE OF CERTIFIER <i>Paul C. Rand MD</i>		29c. LICENSE NUMBER D30929		29d. DATE SIGNED (Month, Day, Year) 4/22/95			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Paul C. Rand, MD 6569 N. Charles St, Baltimore MD 21204															
31. DATE FILED (Month, Day, Year) APR 24 1995				32. REGISTRAR'S SIGNATURE <i>Julia Swickard Randall</i>											

95 13680

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Suzanne Renee Bowman</i>				2. DATE OF DEATH MONTH DAY YEAR <i>APR 22 95</i>		3. TIME OF DEATH <i>1620</i> M	
4. SOCIAL SECURITY NUMBER <i>214-06-3875</i>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <i>11</i> YRS.	7. DATE OF BIRTH (Month, Day, Year) <i>MARCH 7, 1984</i>		8. BIRTHPLACE (State or Foreign Country) <i>MARYLAND</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>ST. AGNES HOSPITAL</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>BALTIMORE</i>		9c. COUNTY OF DEATH <i>N/A</i>	
RESIDENCE OF DECEDENT							
10a. STATE <i>MARYLAND</i>		10b. COUNTY <i>ANNE ARUNDEL</i>		10c. CITY, TOWN OR LOCATION <i>PASADENA</i>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <i>716 209th STREET</i>				10f. ZIP CODE <i>21122</i>		10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>CAUCASIAN</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>N/A</i> College (1-4 or 5+) <i>N/A</i>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>N/A</i>		16b. KIND OF BUSINESS/INDUSTRY <i>N/A</i>	
17. FATHER'S NAME (First, Middle, Last) <i>GLENN BOWMAN, JR.</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>LORETTA A. GRIMES</i>			
19a. INFORMANT'S NAME (Type/Print) <i>LORETTA A. GRIMES SLAYBAUGH</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>716 209th STREET PASADENA, MARYLAND 21122</i>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>ST. JOSEPHS CATH. CH. CEM. 4/25</i>		20c. LOCATION — City or Town, State <i>TANEYTOWN, MARYLAND</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>P. Kevin Jady</i>				22. NAME AND ADDRESS OF FACILITY <i>136 EAST BALTIMORE STREET SKILES FUNERAL HOME TANEYTOWN, MD 21787</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>aspiration pneumonia</i> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. <i>cerebral palsy - mental retardation</i> c. d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>asthma</i> <i>seizure history</i>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Kenneth R Koskinen</i>				29c. LICENSE NUMBER <i>D05858</i>		29d. DATE SIGNED (Month, Day, Year) <i>APR 22 95</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>KENNETH R KOSKINEN</i> <i>Director of Pediatric Emergency Dept SAH Balto</i>							
31. DATE FILED (Month, Day, Year) <i>APR 24 1995</i>				32. REGISTRAR'S SIGNATURE <i>John H. Hall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13681

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) RUBIN BERNSTEIN				2. DATE OF DEATH MONTH APRIL DAY 16 YEAR 1995		3. TIME OF DEATH 12:15 P M	
4. SOCIAL SECURITY NUMBER 419-38-5377		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 86 YRS.		7. DATE OF BIRTH (Month, Day, Year) APRIL 15, 1909	
9a. FACILITY NAME (If not institution, give street and number) HEBREW HOME OF GREATER WASHINGTON				9b. CITY, TOWN OR LOCATION OF DEATH ROCKVILLE		9c. COUNTY OF DEATH MONTGOMERY	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY MONTGOMERY		10c. CITY, TOWN OR LOCATION SILVER SPRING		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 1317 FENWICK LANE #1107				10f. ZIP CODE 20910		10g. CITIZEN OF WHAT COUNTRY? UNITED STATES	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) _____ College (1-4 or 5+) 5		18a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) WHOLESALE		16b. KIND OF BUSINESS/INDUSTRY DRY GOODS			
17. FATHER'S NAME (First, Middle, Last) NATHAN BERNSTEIN				18. MOTHER'S NAME (First, Middle, Maiden Surname) "UNKNOWN" MERING			
19a. INFORMANT'S NAME (Type/Print) ASIA BERNSTEIN (WIFE)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1316 FENWICK LA. #1107-SILVER SPRING, MD. 20910			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) MT. LEBANON CEMETERY		DATE 4/18		20c. LOCATION — City or Town, State ADELPHI, MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Frank A. Stone</i>				22. NAME AND ADDRESS OF FACILITY DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE-ROCKVILLE, MD. 20852			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → STROKE DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. _____							Approximate Interval Between Onset and Death 1 MONTH
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CORONARY ARTERY DISEASE							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)				28e. DESCRIBE HOW INJURY OCCURED			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>P. Talwar, MD.</i>				29c. LICENSE NUMBER D 36552		29d. DATE SIGNED (Month, Day, Year) APRIL 16, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) P. TALWAR, 6121 MONTROSE RD. ROCKVILLE MD. 20852							
31. DATE FILED (Month, Day, Year) APR 18 1995				32. REGISTRAR'S SIGNATURE <i>Julia Davidson Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13682

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Doris Baker				2. DATE OF DEATH MONTH DAY YEAR April 10, 1995		3. TIME OF DEATH 3:30 PM	
4. SOCIAL SECURITY NUMBER 217-14-7086		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 73 YRS.		7. DATE OF BIRTH (Month, Day, Year) Nov. 16, 1921	
9a. FACILITY NAME (If not institution, give street and number) 3413 Dunnington Road				9b. CITY, TOWN OR LOCATION OF DEATH Beltsville		9c. COUNTY OF DEATH Prince Georges	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Prince Georges		10c. CITY, TOWN OR LOCATION Beltsville		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 3413 Dunnington Road				10f. ZIP CODE 20705		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Research Chemist		15b. KIND OF BUSINESS/INDUSTRY U.S. Dept. of Agriculture			
17. FATHER'S NAME (First, Middle, Last) Isaac Baker				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mabel Rhodes			
19a. INFORMANT'S NAME (Type/Print) Lee Cagey				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9809 Doulton Court, Fairfax, Virginia 22032			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Colesville Cemetery		DATE 4/13		20c. LOCATION — City or Town, State Silver Spring, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Lani J. Holland</i>				22. NAME AND ADDRESS OF FACILITY Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland 20904			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Diabetic Hypertensive arteriosclerosis cardiovascular disease</i> DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death Years Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Augusto P. Rodriguez MD</i>				29c. LICENSE NUMBER D-212-30		29d. DATE SIGNED (Month, Day, Year) April 14, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Augusto P. Rodriguez MD, 5009 Rayburn Ct. Cp Spr. Md 20748</i>							
31. DATE FILED (Month, Day, Year) APR 17 1995				32. REGISTRAR'S SIGNATURE <i>John A. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Amended #8, 4/19/95 MRT Montgomery County 95 13683
 1 - FOR STATE REGISTRAR
 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH
 REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ALPHONSO J BURRELL				2. DATE OF DEATH MONTH Apr DAY 17 YEAR 1995		3. TIME OF DEATH 12:45 p.m.	
4. SOCIAL SECURITY NUMBER 579 42 8354		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 62 YRS.		7. DATE OF BIRTH (Month, Day, Year) March 22, 1933	
8. BIRTHPLACE (State or Foreign Country) Fredericksburg, VA				9a. FACILITY NAME (If not institution, give street and number) Malcolm Grow USAF Medical Center		9b. CITY, TOWN OR LOCATION OF DEATH Andrews AFB Maryland	
9c. COUNTY OF DEATH Prince George's				10a. STATE Maryland			
10b. COUNTY Prince George's				10c. CITY, TOWN OR LOCATION Camp Springs			
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER 7317 Wessex Drive			
10f. ZIP CODE 20748				10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Computer Programmer		16b. KIND OF BUSINESS/INDUSTRY U.S. Government			
17. FATHER'S NAME (First, Middle, Last) Herbert Burrell				18. MOTHER'S NAME (First, Middle, Maiden Surname) Emily Jackson			
19a. INFORMANT'S NAME (Type/Print) Luiclle Burrell				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7317 Wessex Dr., Camp Springs, MD. 20748			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Ft. Lincoln Cemetery 4/22/95		20c. LOCATION — City or Town, State Brentwood, Md.		21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>	
22. NAME AND ADDRESS OF FACILITY McGuire Funeral Service Inc. 7400 Georgia Ave., N.W., Wash., D.C. 20012		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. BRAIN STEM HERNIATION & SEQUELA DUE TO (OR AS A CONSEQUENCE OF): b. HEMORRHAGIC DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO						DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER MD 44705		29d. DATE SIGNED (Month, Day, Year) 4/17/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MALCOLM P. SALATA, CAPT, USAF, MC Andrews AFB MD 20331-6600							
31. DATE FILED (Month, Day, Year) APR 19 1995				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13684

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Jack E. BOIES				2. DATE OF DEATH MONTH DAY YEAR April 18 95		3. TIME OF DEATH HOURS MINUTES AM/PM 5:50 A M	
4. SOCIAL SECURITY NUMBER 466-03-7597		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 74 YRS.		7. DATE OF BIRTH (Month, Day, Year) Nov. 27, 1920	
8. FACILITY NAME (If not institution, give street and number) Perry Point VA Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Perryville		9c. COUNTY OF DEATH Cecil	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Potomac		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 12224 Greenleaf Avenue				10f. ZIP CODE 20854		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES World War II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Owner		16b. KIND OF BUSINESS/INDUSTRY Janitorial Service			
17. FATHER'S NAME (First, Middle, Last) Joel Leslie Boies				18. MOTHER'S NAME (First, Middle, Maiden Surname) Nell Freeman			
19a. INFORMANT'S NAME (Type/Print) Dorothy H. Boies				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12224 Greenleaf Avenue, Potomac, Maryland 20854			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Montgomery Crematorium, Inc. April 19, 1995		20c. LOCATION — City or Town, State Bethesda, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Robert A. Pumphrey</i> M00831				22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute Respiratory Failure DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. DESCRIBE HOW INJURY OCCURRED			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>R. Freeman</i>				29c. LICENSE NUMBER MD # D37065		29d. DATE SIGNED (Month, Day, Year) 4-18-95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) RICHARD FREEMAN, M.D. VAMC PERRY POINT, MD 21902							
31. DATE FILED (Month, Day, Year) APR 19 1995				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13685

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Mary Agnes Beckley</u>				2. DATE OF DEATH MONTH <u>April</u> DAY <u>15</u> YEAR <u>1995</u>		3. TIME OF DEATH <u>12:25pm</u> M	
4. SOCIAL SECURITY NUMBER <u>578-09-8043</u>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>85</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>June 24, 1909</u>	
9a. FACILITY NAME (If not institution, give street and number) <u>Suburban Hospital</u>				9b. CITY, TOWN OR LOCATION OF DEATH <u>Bethesda</u>		9c. COUNTY OF DEATH <u>Montgomery</u>	
10a. STATE <u>Maryland</u>				10b. COUNTY <u>Montgomery</u>		10c. CITY, TOWN OR LOCATION <u>Bethesda</u>	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER <u>10250 West Lake Drive #805</u>				10f. ZIP CODE <u>20817</u>		10g. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>White</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u></u>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Waitress</u>		16b. KIND OF BUSINESS/INDUSTRY <u>Restaurant</u>	
17. FATHER'S NAME (First, Middle, Last) <u>Henry Jones</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Annie McIntyre</u>			
19a. INFORMANT'S NAME (Type/Print) <u>Joseph C. Beckley</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>83 Eagle Trail, Carroll Valley, PA 17320</u>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Lower Marsh Creek Cem. 4/19/95</u>		20c. LOCATION — City or Town, State <u>Gettysburg, PA</u>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>[Signature]</u>				22. NAME AND ADDRESS OF FACILITY <u>DeVol Funeral Home</u> <u>10 East Deer Park Drive</u> <u>Gaithersburg, MD 20877</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Lung Cancer</u>							
DUE TO (OR AS A CONSEQUENCE OF):							
b. <u>Chronic obstructive Pulmonary Disease</u>							
DUE TO (OR AS A CONSEQUENCE OF):							
c. <u></u>							
DUE TO (OR AS A CONSEQUENCE OF):							
d. <u></u>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Hypertension</u>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <u>M</u>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <u>[Signature] M.D.</u>				29c. LICENSE NUMBER <u>044157</u>		29d. DATE SIGNED (Month, Day, Year) <u>April 15, 1995</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>IRA BERGER M.D. 809 Veits mill ROAD, Rockville, Maryland 20851</u>							
31. DATE FILED (Month, Day, Year) <u>APR 20 1995</u>				32. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13686

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Marlis Hildegard Borscheid				2. DATE OF DEATH MONTH DAY YEAR April 14, 1995		3. TIME OF DEATH 6:15 P.M.	
4. SOCIAL SECURITY NUMBER 214-60-1933		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 64 YRS.		7. DATE OF BIRTH (Month, Day, Year) February 24, 1931	
9a. FACILITY NAME (If not institution, give street and number) 4423-204 Romlon Street				9b. CITY, TOWN OR LOCATION OF DEATH Beltsville		9c. COUNTY OF DEATH Prince George's	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Prince George's		10c. CITY, TOWN OR LOCATION Beltsville		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 4423 -204 Romlon Street				10f. ZIP CODE 20705		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) +1		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Underwriter		16b. KIND OF BUSINESS/INDUSTRY GEICO Insurance Co.			
17. FATHER'S NAME (First, Middle, Last) Wilhelm Borscheid				18. MOTHER'S NAME (First, Middle, Maiden Surname) Hedwig			
19a. INFORMANT'S NAME (Type/Print) Deborah A. Luongo				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4423 -102 Romlon Street Beltsville, Maryland 20705			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metropolitan Crematory April 18, 1995		20c. LOCATION — City or Town, State Alexandria, Virginia			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Donald V. Borgwardt</i>				22. NAME AND ADDRESS OF FACILITY Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Md. 20705			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Pancreatic Cancer							
a. DUE TO (OR AS A CONSEQUENCE OF):							
b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Luis Casas M.D.</i>				29c. LICENSE NUMBER D24997		29d. DATE SIGNED (Month, Day, Year) 4/17/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Luis Casas, M.D. 8317 Cherry Lane Laurel, Maryland 20707							
31. DATE FILED (Month, Day, Year) APR 20 1995				32. REGISTRAR'S SIGNATURE <i>John A. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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95 13687

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) MARCELLA ANN BERILLA				2. DATE OF DEATH MONTH DAY YEAR April 14, 1995		3. TIME OF DEATH 8:00 A M	
4. SOCIAL SECURITY NUMBER 181-22-7146		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	8. AGE (In yrs. last birthday) 68 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Feb. 11, 1927	
9a. FACILITY NAME (If not institution, give street and number) 3615 Edelmarr Terrace				9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring		9c. COUNTY OF DEATH Montgomery	
10a. STATE Maryland				10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Silver Spring	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER 3615 Edelmarr Terrace				10f. ZIP CODE 20906		10g. CITIZEN OF WHAT COUNTRY? United States	
11. FATHER'S NAME (First, Middle, Last) Joseph Kubik		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Clerical		16b. KIND OF BUSINESS/INDUSTRY Steel Industry			
17. FATHER'S NAME (First, Middle, Last) Joseph Kubik				18. MOTHER'S NAME (First, Middle, Maiden Surname) Marie Gorak			
19a. INFORMANT'S NAME (Type/Print) Thomas Berilla				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3615 Edelmarr Terrace, Silver Spring, Maryland 20906			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation / 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gate of Heaven Cemetery 4/18		20c. LOCATION — City or Town, State Silver Spring, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSE <i>Thomas Berilla</i>				22. NAME AND ADDRESS OF FACILITY Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Renal CELL CARCINOMA</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>BRAIN METASTASES</u> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE (NO TITLE OF CERTIFIER) <i>Joseph Keplan</i>				29c. LICENSE NUMBER D 35 635		29d. DATE SIGNED (Month, Day, Year) 4/18/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Joseph Keplan 18111 Prince Philip Dr. Silver Spring, MD 20906							
31. DATE FILED (Month, Day, Year) APR 21 1995		32. REGISTRAR'S SIGNATURE <i>John A. Randall</i>					

DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

18

95 13688

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) RICHARD Lewis Bruce, Jr.				2. DATE OF DEATH MONTH April DAY 19 YEAR 95		3. TIME OF DEATH 6:00 M	
4. SOCIAL SECURITY NUMBER 214-80-4006		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 39 YRS.		7. DATE OF BIRTH (Month, Day, Year) March 22, 1956	
8. BIRTHPLACE (State or Foreign Country) Washington, DC				9a. FACILITY NAME (If not institution, give street and number) Cradock Group Home		9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring	
9c. COUNTY OF DEATH Montgomery				10a. STATE Maryland		10b. COUNTY Montgomery	
10c. CITY, TOWN OR LOCATION Silver Spring				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 1925 Cradock Street	
10f. ZIP CODE 20904				10g. CITIZEN OF WHAT COUNTRY? United States		11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: White				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+) None			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) None				16b. KIND OF BUSINESS/INDUSTRY None			
17. FATHER'S NAME (First, Middle, Last) Richard Lewis Bruce				18. MOTHER'S NAME (First, Middle, Maiden Surname) Eleanor M. MacArthur			
19a. INFORMANT'S NAME (Type/Print) Susan B. Luecker				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 691 Genessee Street Annapolis, Maryland 21401			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Montgomery Crematorium, Inc.			
20c. LOCATION — City or Town, State Bethesda, Maryland				21. SIGNATURE OF FUNERAL SERVICE LICENSEE Delmar J. Lento M00202			
22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Seizure Disorder Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Group Home			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year) April 19 95			
28b. TIME OF INJURY M				28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER John T. Taylor				29c. LICENSE NUMBER D08546			
29d. DATE SIGNED (Month, Day, Year) April 19 95				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John T. Taylor 8218 Wisconsin Ave Bethesda			
31. DATE FILED (Month, Day, Year) APR 21 1995				32. REGISTRAR'S SIGNATURE Julia Pawlson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13689

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Mildred L. Brock				2. DATE OF DEATH 4-20-95 MONTH DAY YEAR April 20 95		3. TIME OF DEATH 0025 M	
4. SOCIAL SECURITY NUMBER 428-28-0413		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 74 YRS.		7. DATE OF BIRTH (Month, Day, Year) May 3, 1920	
9a. FACILITY NAME (If not institution, give street and number) Union Hospital of Cecil County				9b. CITY, TOWN OR LOCATION OF DEATH Elkton		9c. COUNTY OF DEATH Cecil	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Cecil		10c. CITY, TOWN OR LOCATION Elkton		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 122 East Village Road				10f. ZIP CODE 21921		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (8-12) 8		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Assembly Person		15b. KIND OF BUSINESS/INDUSTRY Electric Motors			
17. FATHER'S NAME (First, Middle, Last) Charles Smith				18. MOTHER'S NAME (First, Middle, Maiden Surname) Effie Dodd			
19a. INFORMANT'S NAME (Type/Print) Michael R. Brock				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 122 East Village Road - Elkton, MD 21921			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gilpin Manor Memorial Park 4-22-95		20c. LOCATION — City or Town, State Elkton, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Donald S. Hicks</i>				22. NAME AND ADDRESS OF FACILITY Hicks Home for Funerals, P.A. 103 West Stockton Street Elkton, MD 21921-5521			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. CVA Now and local DUE TO (OR AS A CONSEQUENCE OF):				Approximate Interval Between Onset and Death 7 days	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST		b. COPD DUE TO (OR AS A CONSEQUENCE OF):				15 yrs	
		c. Aspiration pneumonia DUE TO (OR AS A CONSEQUENCE OF):				7 days	
		d. ASCVD DUE TO (OR AS A CONSEQUENCE OF):				10 yrs	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Jui-chih Hsu MD</i>				29c. LICENSE NUMBER D04823		29d. DATE SIGNED (Month, Day, Year) 4/24/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Jui-chih Hsu MD 223 West main st, Elkton MD 21921							
31. DATE FILED (Month, Day, Year) APR 25 1995				32. REGISTRAR'S SIGNATURE <i>Judi Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13690

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Martha Elizabeth BLUME				2. DATE OF DEATH MONTH DAY YEAR April 22 1995		3. TIME OF DEATH 10:12 A M	
4. SOCIAL SECURITY NUMBER 214-09-5608		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 89 YRS.		7. DATE OF BIRTH (Month, Day, Year) Aug. 15, 1905	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. CITY, TOWN OR LOCATION OF DEATH Williamsport		9c. COUNTY OF DEATH Washington	
10a. STATE Maryland				10b. COUNTY Washington		10c. CITY, TOWN OR LOCATION Williamsport	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 16505 Virginia Avenue		10f. ZIP CODE 21795	
10g. CITIZEN OF WHAT COUNTRY? U.S.A.				11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 Years College (1-4 or 5+) College				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Personal Residence	
17. FATHER'S NAME (First, Middle, Last) Charles F. Blickenstaff				18. MOTHER'S NAME (First, Middle, Maiden Surname) Lizzie M. Palmer			
19a. INFORMANT'S NAME (Type/Print) Joseph M. Blickenstaff				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 308 Avon Road, Hagerstown, Maryland 21740			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Rest Haven Cemetery 4/25/95		20c. LOCATION — City or Town, State Hagerstown, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Douglas A. Fiery				22. NAME AND ADDRESS OF FACILITY Douglas A. Fiery Funeral Home 21742 1331 Eastern Blvd. North, Hagerstown, MD			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. SCISSORS Due to (OR AS A CONSEQUENCE OF): b. PNEUMONIA Due to (OR AS A CONSEQUENCE OF): c. ASPIRATION Due to (OR AS A CONSEQUENCE OF): d. CHEST PAIN Approximate interval Between Onset and Death Days Days Days Months							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURRED					
28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)		29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER Stephen M. Diacosta		29c. LICENSE NUMBER 1706		29d. DATE SIGNED (Month, Day, Year) 4/24/95			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Stephen M. Diacosta, MD 787 North Ave Hagerstown, MD							
31. DATE FILED (Month, Day, Year) APR 26 1995		32. REGISTRAR'S SIGNATURE John A. ...					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13691

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Mary Jane Bowman</i>				2. DATE OF DEATH MONTH <i>April</i> DAY <i>16</i> YEAR <i>1995</i>		3. TIME OF DEATH <i>2:09</i> M	
4. SOCIAL SECURITY NUMBER <i>214-09-8191</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>78</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>Sept 5, 1916</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Washington County Hospital</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Hagerstown</i>		9c. COUNTY OF DEATH <i>Washington</i>	
10a. STATE <i>Maryland</i>				10b. COUNTY <i>Washington</i>		10c. CITY, TOWN OR LOCATION <i>Hagerstown</i>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <i>17321 Diane Drive</i>			
10f. ZIP CODE <i>21740</i>				10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>white</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>0</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>teacher's aide</i>		16b. KIND OF BUSINESS/INDUSTRY <i>school</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Walter Halback</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Jennie Smith</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Kenneth Harbaugh</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>17323 Diane Dr., Hagerstown, Maryland 21740</i>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Hagerstown Crematory 4-18-95</i>		20c. LOCATION — City or Town, State <i>Hagerstown, Maryland</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Scott M. Minnich</i>				22. NAME AND ADDRESS OF FACILITY <i>MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Widespread abdominal malignancy</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>primary site unclear</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i>Cerebrovascular accident</i> DUE TO (OR AS A CONSEQUENCE OF): d. <i>Thrombocytopenia</i>							Approximate Interval Between Onset and Death <i>unk</i> <i>Unknown</i> <i>Unknown</i>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Lawrence L. Parker M.D.</i>				29c. LICENSE NUMBER <i>D09930</i>		29d. DATE SIGNED (Month, Day, Year) <i>4-16-95</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Lawrence L. Parker M.D. 145 W. Washington St. Hagerstown, Md.</i>							
31. FILED (Month, Day, Year) <i>APR 20 1995</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Handwritten text, possibly a signature or date, located near the bottom center of the page.

95 13692

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Donald Franklin Boyd</i>				2. DATE OF DEATH MONTH DAY YEAR 4-16-1995		3. TIME OF DEATH 13:20 PM	
4. SOCIAL SECURITY NUMBER 218-24-1810		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 66 YRS.		7. DATE OF BIRTH (Month, Day, Year) 10-6-1928	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) Washington County Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Hagerstown	
9c. COUNTY OF DEATH Washington				10a. STATE Maryland		10b. COUNTY Washington	
10c. CITY, TOWN OR LOCATION Williamsport				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 16822 Tammany Manor Road	
10f. ZIP CODE 21795				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1947 - 1951				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life) Refrigeration Technician		16b. KIND OF BUSINESS/INDUSTRY General Motors Corp.	
17. FATHER'S NAME (First, Middle, Last) Frank Mish Boyd				18. MOTHER'S NAME (First, Middle, Maiden Surname) Louise T. Seibert			
19a. INFORMANT'S NAME (Type/Print) Bernice Elizabeth Boyd				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16822 Tammany Manor Rd. Williamsport, MD 21795			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium or other place) Rose Hill 4-19-1995		20c. LOCATION — City or Town, State Clear Spring, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Craig H. Olson</i>				22. NAME AND ADDRESS OF FACILITY Thompson Funeral Home, Inc. P.O. Box 310 Clear Spring, MD 21722			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Acute Respiratory Failure</i> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { b. <i>Pneumonia</i> c. <i>Inoperable metastatic large cell/squamous cell CA of the lung</i> d. <i>cell CA of the lung</i>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>COPD</i>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
25. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> M.D.				29c. LICENSE NUMBER D44431		29d. DATE SIGNED (Month, Day, Year) 4/16/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>JOSEPH L. CORRECCOS, M.D., WASH. COUNTY HOSP.</i>							
31. DATE FILED (Month, Day, Year) APR 18 1995				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death with the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13693

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Mary Magdalene Bishop				2. DATE OF DEATH MONTH DAY YEAR 04-12-1995		3. TIME OF DEATH approx 0800M	
4. SOCIAL SECURITY NUMBER 213-40-6820		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) 79 YRS.		7. DATE OF BIRTH MONTH DAY YEAR 11-8-1915	
9a. FACILITY NAME (If not institution, give street and number) Washington County Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Hagerstown,		9c. COUNTY OF DEATH Washington	
10a. STATE MD.				10b. COUNTY Washington		10c. CITY, TOWN OR LOCATION Clear Spring,	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STATE AND NUMBER 12657 Big Pool Road.			
10f. ZIP CODE 21722				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Personal Residence			
17. FATHER'S NAME (First, Middle, Last) George Mc Cullough				18. MOTHER'S NAME (First, Middle, Maiden Surname) Harriett Bishop			
19a. INFORMANT'S NAME (Type/Print) Linda Wigfield				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12645 Big Pool Rd. Clear Spring, MD 21722			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium or other place) Rest Haven Cemetery 4/14/95		20c. LOCATION — City or Town, State Hagerstown, MD		20d. DATE 4/14/95	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Thompson Funeral Home Inc. P.O. Box 310 Clear Spring, MD 21722			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute myocardial infarction, hypertensive DUE TO (OR AS A CONSEQUENCE OF): b. Atherosclerotic cardiovascular disease DUE TO (OR AS A CONSEQUENCE OF): c. Diabetes mellitus, type II DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate interval Between Onset and Death Sudden year
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes mellitus, type II							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> POA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Nomicide 7 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) NONE		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D06040		29d. DATE SIGNED (Month, Day, Year) 04-12-95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Barry M. Cohen, 18906 CRESTWOOD PA, HAGERSTOWN, MD, 21742							
31. DATE FILED (Month, Day, Year) APR 13 1995		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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95 13694

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Margaret Jennie Baker</u>				2. DATE OF DEATH MONTH <u>April</u> DAY <u>19</u> YEAR <u>1995</u>				3. TIME OF DEATH <u>7:15 P M</u>	
4. SOCIAL SECURITY NUMBER <u>217-20-5611</u>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>68</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>08-02-1926</u>		8. BIRTHPLACE (State or Foreign Country) <u>MD</u>	
9a. FACILITY NAME (If not institution, give street and number) <u>Union Memorial Hospital</u>				9b. CITY, TOWN OR LOCATION OF DEATH <u>Baltimore</u>				9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT									
10a. STATE <u>MD</u>		10b. COUNTY <u>Harford</u>		10c. CITY, TOWN OR LOCATION <u>Havre de Grace</u>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <u>140 Deaver Street</u>				10f. ZIP CODE <u>21078</u>		10g. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>White</u>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>9</u> College (1-4 or 5+) <u></u>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Homemaker</u>		16b. KIND OF BUSINESS/INDUSTRY <u>Home</u>					
17. FATHER'S NAME (First, Middle, Last) <u>John Leonard Owens</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Louise Orr</u>					
19a. INFORMANT'S NAME (Type/Print) <u>Mr. Ronald P. Baker, Sr.</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>312 Lafayette St., Havre de Grace, MD 21078</u>					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Angel Hill Cemetery</u>		DATE <u>4/24</u>		20c. LOCATION — City or Town, State <u>Havre de Grace, MD</u>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>[Signature]</u>				22. NAME AND ADDRESS OF FACILITY <u>Mitchell-Smith Funeral Home, P.A. Havre de Grace, MD 21078-3197</u>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>a. End Stage Renal Disease</u> DUE TO (OR AS A CONSEQUENCE OF): <u>b. Diabetes Mellitus</u> DUE TO (OR AS A CONSEQUENCE OF): <u>c.</u> DUE TO (OR AS A CONSEQUENCE OF): <u>d.</u> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death <u>6mo</u> <u>20 yr</u>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Sacral Decubitus Malnutrition</u> <u>Coronary Artery Disease</u>								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <u>M</u>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <u>Brian Spar, MD</u>		29c. LICENSE NUMBER <u>D29645</u>		29d. DATE SIGNED (Month, Day, Year) <u>4/20/95</u>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>Brian Spar, MD 6565 N Charles St, 5216, Baltimore, Md 21204</u>									
31. DATE FILED (Month, Day, Year) <u>APR 21 1995</u>		32. REGISTRAR'S SIGNATURE <u>Jabin Anderson-Randall</u>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13695

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JOSEPH P. BISHARA				2. DATE OF DEATH MONTH APRIL DAY 15 YEAR 1995		3. TIME OF DEATH 18:06 M	
4. SOCIAL SECURITY NUMBER 113-14-5308		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 68 YRS.		7. DATE OF BIRTH (Month, Day, Year) April 19 1926	
8. BIRTHPLACE (State or Foreign Country) New York				9a. FACILITY NAME (If not Institution, give street and number) THE JOHNS HOPKINS HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY	
9c. COUNTY OF DEATH				10a. STATE MD		10b. COUNTY Anne Arundel	
10c. CITY, TOWN OR LOCATION Annapolis				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 1021 Boucher Avenue	
10f. ZIP CODE 21403				10g. CITIZEN OF WHAT COUNTRY? United States		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE YEAR OR DATES 1944 - 1946				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Salesman		16b. KIND OF BUSINESS/INDUSTRY Food Industry	
17. FATHER'S NAME (First, Middle, Last) Spero Bishara				18. MOTHER'S NAME (First, Middle, Maiden Surname) Selma Aswad			
19a. INFORMANT'S NAME (Type/Print) Alfred Bishara				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 146 Spa Drive Annapolis, Maryland 21403			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Hillcrest Cemetery 4/19/95		20c. LOCATION — City or Town, State Annapolis, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Wayne J. Buehler</i>				22. NAME AND ADDRESS OF FACILITY John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → s. Ventricular tachycardia DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. Coronary artery disease DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Approximate interval Between Onset and Death s. 10-15 min b. years							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Clark A. Calver MD</i>				29c. LICENSE NUMBER L 9424		29d. DATE SIGNED (Month, Day, Year) 4/16/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JOHNS HOPKINS 6th Floor JHOC Johns Hopkins Hospital Baltimore MD							
31. DATE FILED (Month, Day, Year) APR 19 1995				32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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95 13696

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Ethel Blake</i>				2. DATE OF DEATH MONTH DAY YEAR APRIL 15 1995				3. TIME OF DEATH 7:35 am M				
4. SOCIAL SECURITY NUMBER 212-34-0108		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 60 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) DEC. 11 1934		8. BIRTHPLACE (State or Foreign Country) MARYLAND			
9a. FACILITY NAME (If not institution, give street and number) ANNE ARUNDEL MEDICAL CENTER					9b. CITY, TOWN OR LOCATION OF DEATH ANNAPOLIS				9c. COUNTY OF DEATH ANNE ARUNDEL			
RESIDENCE OF DECEDENT												
10a. STATE MARYLAND		10b. COUNTY ANNE ARUNDEL		10c. CITY, TOWN OR LOCATION HARWOOD				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				
10e. STREET AND NUMBER 4336 MUDDY CREEK ROAD					10f. ZIP CODE 20776			10g. CITIZEN OF WHAT COUNTRY? USA				
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: BLACK				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12th				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) NURSE				16b. KIND OF BUSINESS/INDUSTRY CROWNSVILLE ST. HOSPITAL				
17. FATHER'S NAME (First, Middle, Last) THOMAS DORSEY						18. MOTHER'S NAME (First, Middle, Maiden Surname) MARY ROSS						
19a. INFORMANT'S NAME (Type/Print) JAMES P. BLAKE						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4336 MUDDY CREEK RD. HARWOOD, MD. 20776						
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MOSES CEMETERY 4/20/95				20c. LOCATION — City or Town, State DRURY, MD.				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Larry H. Reese</i>						22. NAME AND ADDRESS OF FACILITY REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>ASCVD</i> DUE TO (OR AS A CONSEQUENCE OF): Approximate interval between Onset and Death <i>more than 1 month</i> <i>27</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.												
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO												
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO												
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>												
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>Wayne Briggs MD</i>				29c. LICENSE NUMBER D28640		29d. DATE SIGNED (Month, Day, Year) 4/15/95		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 556 Cardinal Drive Pasadena MD 2122												
31. DATE FILED (Month, Day, Year) APR 18 1995				32. REGISTRAR'S SIGNATURE <i>John Andrew Randall</i>								

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13697

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) WILLIAM A. CAMPBELL				2. DATE OF DEATH MONTH APRIL DAY 14 YEAR 1995		3. TIME OF DEATH 0648A	
4. SOCIAL SECURITY NUMBER 217-28-6861		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 63 YRS.		7. DATE OF BIRTH (Month, Day, Year) Jan. 6, 1932	
9a. FACILITY NAME (If not institution, give street and number) Shady Grove Adventist Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Rockville		9c. COUNTY OF DEATH MONTGOMERY	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Gaithersburg		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 12224 Quince Valley Dr.				10f. ZIP CODE 20878		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES Korean War		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2 yrs College (1-4 or 5+) 2 yrs				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Machinist		16b. KIND OF BUSINESS/INDUSTRY Auto Company	
17. FATHER'S NAME (First, Middle, Last) Robert L. Campbell				18. MOTHER'S NAME (First, Middle, Maiden Surname) Elsie Berry			
19a. INFORMANT'S NAME (Type/Print) Nannie P. Campbell (Wife)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12224 Quince Valley Dr., Gaithersburg, MD 20878			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Pleasant View Cem. 4/18		20c. LOCATION — City or Town, State Rockville, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>George R. Snowden</i>				22. NAME AND ADDRESS OF FACILITY SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. Acute Myocardial infarction					Approximate Interval Between Onset and Death 45 min
		b. Coronary Artery Disease					20 years
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		c. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETES Mellitus							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Wayne A. Friestad MD</i>				29c. LICENSE NUMBER D 30 900		29d. DATE SIGNED (Month, Day, Year) April 14, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) WAYNE FRIESTAD MD 9901 Medical Center Dr. Rockville, MD							
31. DATE FILED (Month, Day, Year) APR 18 1995				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Rodall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13698

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) LUISA CHIEDI				2. DATE OF DEATH MONTH APRIL DAY 13 YEAR 1995				3. TIME OF DEATH 2:10 P M	
4. SOCIAL SECURITY NUMBER 163-26-1688		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 78 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS. HOURS 0 MIN. 0	
7. DATE OF BIRTH (Month, Day, Year) Oct. 4, 1916				8. BIRTHPLACE (State or Foreign Country) Pennsylvania					
9a. FACILITY NAME (If not institution, give street and number) Southern Maryland Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Clinton				9c. COUNTY OF DEATH PRINCE GEORGES	
RESIDENCE OF DECEDENT									
10a. STATE MD		10b. COUNTY Prince Georges		10c. CITY, TOWN OR LOCATION Upper Marlboro				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 7107 Antock Place				10f. ZIP CODE 20735		10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 5 College (1-4 or 5+) 0				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker				16b. KIND OF BUSINESS/INDUSTRY Home	
17. FATHER'S NAME (First, Middle, Last) Antonino Prestandrea				18. MOTHER'S NAME (First, Middle, Maiden Surname) Concetta Briguglio					
19a. INFORMANT'S NAME (Type/Print) Ione Greenawalt				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15944 Indian Hills Terrace, Rockville, MD 20855					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gate of Heaven		DATE 4/17/95		20c. LOCATION — City or Town, State Silver Spring, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Theresa Rinaldi</i>				22. NAME AND ADDRESS OF FACILITY Hines-Rinaldi Funeral Home 11800 New Hampshire Ave Silver Spring MD					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. CARDIO-PULMONARY ARREST DUE TO (OR AS A CONSEQUENCE OF): b. Compression of Left middle cerebral artery DUE TO (OR AS A CONSEQUENCE OF): c. Subdural Hematoma DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Atherosclerosis, Diabetes mellitus								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO									
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>J. Berger MD</i>				29c. LICENSE NUMBER D25925		29d. DATE SIGNED (Month, Day, Year) Apr 14, 1995			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J. BERGER MD #205, 7720 WISCONSIN AVE Bethesda Md 20814									
31. DATE FILED (Month, Day, Year) APR 17 1995				32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13699

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) James A. Crawford, Jr.				2. DATE OF DEATH April 10 1995		3. TIME OF DEATH 11:30 P M	
4. SOCIAL SECURITY NUMBER 577-03-4812		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 84 YRS.	7. DATE OF BIRTH (Month, Day, Year) Aug. 25, 1910		8. BIRTHPLACE (State or Foreign Country) Washington, D.C.	
9a. FACILITY NAME (If not institution, give street and number) Montgomery General Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Olney		9c. COUNTY OF DEATH Montgomery	
RESIDENCE OF DECEASED							
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Silver Spring		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 15101 Interlachen Drive, Apt. 816				10f. ZIP CODE 20906		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2				16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Assistant Treasurer		16b. KIND OF BUSINESS/INDUSTRY Insurance	
17. FATHER'S NAME (First, Middle, Last) James A. Crawford, Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Florence M. Stephens			
19a. INFORMANT'S NAME (Type/Print) Ann Crawford				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15101 Interlachen Drive, Apt. 816, Silver Spring, MD 20906			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) Cedar Hill Cemetery		20c. DATE 4/13		20d. LOCATION — City or Town, State Suitland, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland 20904			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. VENTRICULAR ARHYTHMIA							
DUE TO (OR AS A CONSEQUENCE OF):							
b. ATHEROSCLEROTIC HEART DISEASE							
DUE TO (OR AS A CONSEQUENCE OF):							
c. HYPERTENSIVE CARDIOVASCULAR DISEASE							
DUE TO (OR AS A CONSEQUENCE OF):							
d.							
Approximate Interval Between Onset and Death 11 months 15 years 15 years							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PERIPHERAL VASCULAR DISEASE							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D 16145		29d. DATE SIGNED (Month, Day, Year) APRIL 11 - 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) GREGORIO KORN MD 15225 SHADY GROVE RD, ROCKVILLE, MD							
31. DATE FILED (Month, Day, Year) APR 11 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 13700

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) AGNES A. CARRICK				2. DATE OF DEATH MONTH APRIL DAY 13 YEAR 1995		3. TIME OF DEATH 11:40 P M	
4. SOCIAL SECURITY NUMBER 579-84-4952		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 80 YRS.		7. DATE OF BIRTH (Month, Day, Year) SEPT. 26, 1914	
8. BIRTHPLACE (State or Foreign Country) WASH. D.C.				9. COUNTY OF DEATH MONTGOMERY			
9a. FACILITY NAME (If not institution, give street and number) KENSINGTON GARDENS NURSING CENTER				9b. CITY, TOWN OR LOCATION OF DEATH KENSINGTON			
10a. STATE MD.				10b. COUNTY PRINCE GEORGES		10c. CITY, TOWN OR LOCATION CAPITOL HEIGHTS	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER 23 MARYLAND PARK DR.			
10f. ZIP CODE 20743				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOUSEWIFE		15b. KIND OF BUSINESS/INDUSTRY AT HOME			
17. FATHER'S NAME (First, Middle, Last) JOHN M. MCKIMMIE				18. MOTHER'S NAME (First, Middle, Maiden Surname) MABEL I. SANFORD			
19a. INFORMANT'S NAME (Type/Print) PHYLLIS J. NEIDENBACH				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4709 OXBOW RD., ROCKVILLE, MD. 20852			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) CHAMBERS CREMATORY		20c. LOCATION — City or Town, State 4/14/95 RIVERDALE, MD.		20d. DATE 4/14/95	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>W. W. Chambers</i> MO0091				22. NAME AND ADDRESS OF FACILITY W. W. CHAMBERS CO. INC., SILVER SPRING, MD. 20910			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. new stroke (presumed) DUE TO (OR AS A CONSEQUENCE OF): b. hypertension DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death Hours years
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. mis strokes malnutrition							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>David A. Blass MD</i>				29c. LICENSE NUMBER D23911		29d. DATE SIGNED (Month, Day, Year) April 14, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) David A. Blass MD 9410 Old Georgetown Road Bethesda, Md. 20814							
31. DATE FILED (Month, Day, Year) APR 17 1995				32. REGISTRAR'S SIGNATURE <i>Jane Davidson-Rodall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

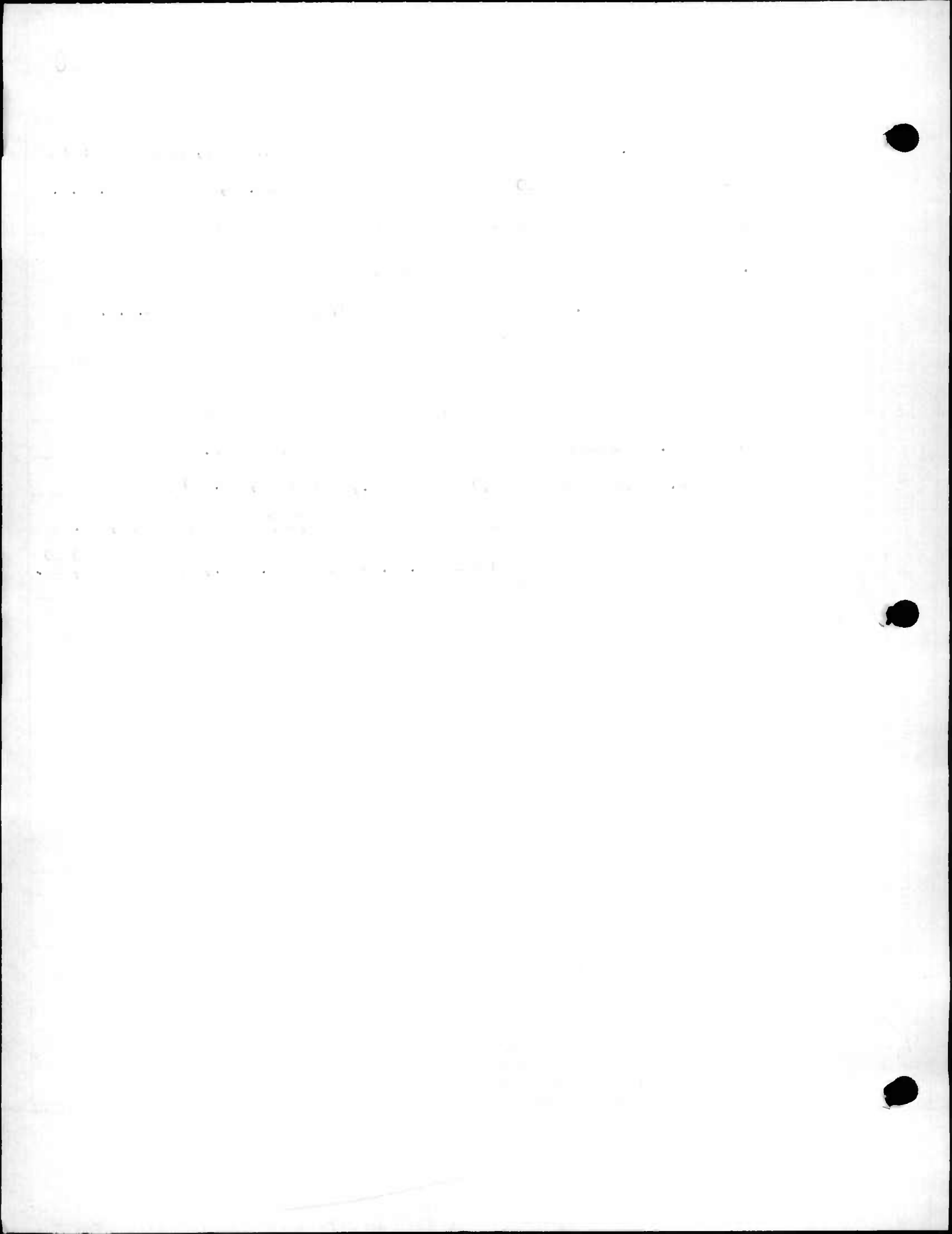
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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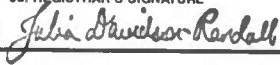
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 13701

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Bernadette Helen Connolly				2. DATE OF DEATH MONTH April DAY 16 YEAR 1995				3. TIME OF DEATH 3:00 A.M.		
4. SOCIAL SECURITY NUMBER 187-12-9269		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 73 YRS.	7. DATE OF BIRTH (Month, Day, Year) April 3, 1922		8. BIRTHPLACE (State or Foreign Country) Pennsylvania				
9a. FACILITY NAME (If not institution, give street and number) 1912 Saratoga Drive				9b. CITY, TOWN OR LOCATION OF DEATH Adelphi			9c. COUNTY OF DEATH Prince Georges			
RESIDENCE OF DECEDENT										
10a. STATE Maryland		10b. COUNTY Prince Georges		10c. CITY, TOWN OR LOCATION Adelphi			10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 1912 Saratoga Drive				10f. ZIP CODE 20783		10g. CITIZEN OF WHAT COUNTRY? USA				
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMY FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12			15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Legal Secretary			15b. KIND OF BUSINESS/INDUSTRY Law				
17. FATHER'S NAME (First, Middle, Last) William Joseph O'Rourke				18. MOTHER'S NAME (First, Middle, Maiden Surname) Helen Marie Healy						
19a. INFORMANT'S NAME (Type/Print) William Connolly				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12006 Thackery Court, Bowie, MD 20720						
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gate of Heaven Cemetery 4/19/95			DATE 4/19/95		20c. LOCATION — City or Town, State Silver Spring, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd.W. Sil.Spr. MD 20901						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardio Pulmonary Arrest DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { b. Amyotrophis Lateral Sclerosis DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.									Approximate Interval Between Onset and Death 10 mins. 9 mons.	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>										
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide a <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D 00232		29d. DATE SIGNED (Month, Day, Year) April 17, 1995				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Morton Altschuler, M.D. 1299 Lamberton Drive Silver Spring, MD 20902-3411										
31. DATE FILED (Month, Day, Year) APR 19 1995		32. REGISTRAR'S SIGNATURE 								

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13702

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Miriam Talbott Chapin				2. DATE OF DEATH MONTH DAY YEAR April 17, 1995		3. TIME OF DEATH 6:30 A M	
4. SOCIAL SECURITY NUMBER 218-20-1379		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 88 YRS.		7. DATE OF BIRTH (Month, Day, Year) Sept. 30, 1906	
8a. FACILITY NAME (If not institution, give street and number) Fox Chase Rehabilitation & Nursing Center				8b. CITY, TOWN OR LOCATION OF DEATH Silver Spring		8c. COUNTY OF DEATH Montgomery	
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Silver Spring		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 2015 East West Highway				10f. ZIP CODE 20815		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) Otho H.W. Talbott				18. MOTHER'S NAME (First, Middle, Maiden Surname) Katherine Choate			
19a. INFORMANT'S NAME (Type/Print) James J. Cromwell				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22 West Jefferson Street, Rockville, MD 20850			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Montgomery Crematorium, Inc. April 18, 1995		20c. LOCATION — City or Town, State Bethesda, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Barbara J. McMullen Lawrence</i>		M00831		22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Congestive Heart Failure DUE TO (OR AS A CONSEQUENCE OF): Atrial Fibrillation DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST Carcinoma of Colon, Stroke							Approximate Interval Between Onset and Death 3 days 10 years
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Carcinoma of Colon, Stroke							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Stephen C. Cromwell M.D.</i>				29c. LICENSE NUMBER D1396		29d. DATE SIGNED (Month, Day, Year) 4-18-95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Stephen C. Cromwell, M.D. 615 West Montgomery Avenue, Rockville, MD 20850							
31. DATE FILED (Month, Day, Year) APR 19 1995		32. REGISTRAR'S SIGNATURE <i>J. H. Anderson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

3

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13703

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Mary Elizabeth Cavey				2. DATE OF DEATH MONTH DAY YEAR April 17, 1995		3. TIME OF DEATH 9:50 a.m.	
4. SOCIAL SECURITY NUMBER 579-14-9260		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 85 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Dec. 17, 1909	
8. BIRTHPLACE (State or Foreign Country) Washington, DC				9a. FACILITY NAME (If not institution, give street and number) Holy Cross Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring	
9c. COUNTY OF DEATH Montgomery				10a. STATE Maryland		10b. COUNTY Montgomery	
10c. CITY, TOWN OR LOCATION Montgomery Village				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 10141 Gravier Court	
10f. ZIP CODE 20879				10g. CITIZEN OF WHAT COUNTRY? United States		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Telephone Operator		16b. KIND OF BUSINESS/INDUSTRY National Institute of Health	
17. FATHER'S NAME (First, Middle, Last) Michael J. Moran				18. MOTHER'S NAME (First, Middle, Maiden Surname) Catherine McDonough			
19a. INFORMANT'S NAME (Type/Print) Joyce Murphy				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10141 Gravier Ct. Montgomery Village, MD 20879			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gate of Heaven Cemetery 4/20/95		20c. LOCATION — City or Town, State Silver Spring, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Michael R. Hibbons				22. NAME AND ADDRESS OF FACILITY DeVol Funeral Home 10 East Deer Park Drive Gaithersburg, MD 20877			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Ventricular arrhythmia DUE TO (OR AS A CONSEQUENCE OF): b. Respiratory failure DUE TO (OR AS A CONSEQUENCE OF): c. ARDS Septic DUE TO (OR AS A CONSEQUENCE OF): post op pneumonia for lung cancer Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate interval Between Onset and Death 10 days
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Vicente C. de Guzman				29c. LICENSE NUMBER 3025 MD		29d. DATE SIGNED (Month, Day, Year) 4-18-95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Type/Print) Vicente C. de Guzman, MD 10215 Ferwood Rd #504, Bethesda, MD 20817-1106							
31. DATE FILED (Month, Day, Year) APR 20 1995		32. REGISTRAR'S SIGNATURE John A. ...					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13704

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) HARRY WHITE CULBRETH				2. DATE OF DEATH MONTH APRIL DAY 19 YEAR 1995		3. TIME OF DEATH 9:45 P M	
4. SOCIAL SECURITY NUMBER 275-16-6120		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 90 YRS.		7. DATE OF BIRTH (Month, Day, Year) Sept 14, 1904	
8. BIRTHPLACE (State or Foreign Country) Virginia				9a. FACILITY NAME (If not institution, give street and number) 6909 Marbury Road		9b. CITY, TOWN OR LOCATION OF DEATH Bethesda	
9c. COUNTY OF DEATH Montgomery				10a. STATE Maryland		10b. COUNTY Montgomery	
10c. CITY, TOWN OR LOCATION Bethesda				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 6909 Marbury Road	
10f. ZIP CODE 20817				10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) 4		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Executive		16b. KIND OF BUSINESS/INDUSTRY Insurance			
17. FATHER'S NAME (First, Middle, Last) Henry Clay Culbreth				18. MOTHER'S NAME (First, Middle, Maiden Surname) Henrietta Mosely Hooper			
19a. INFORMANT'S NAME (Type/Print) Mary Elizabeth Culbreth (Wife)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as #10			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Chesapeake Crematory		OATE 4/20		20c. LOCATION — City or Town, State Beltsville, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> M00827				22. NAME AND ADDRESS OF FACILITY Rapp Funeral Services, P.A. 933 Gist Ave, Silver Spring, MD 20910			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Metastatic Prostate Carcinoma Approximate Interval Between Onset and Death 1 month Feb/1985 Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Multiple Myeloma Cerebral Arteriosclerosis							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> Richard B. Perry MD				29c. LICENSE NUMBER 2118		29d. DATE SIGNED (Month, Day, Year) April 20, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Richard B. Perry MD 1145 19th St NW #600 WASH DC 20036-3781							
31. DATE FILED (Month, Day, Year) APR 21 1995				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13705

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Thomas Nelson Carter, M.D.				2. DATE OF DEATH MONTH DAY YEAR April 15, 1995		3. TIME OF DEATH 7:30 PM	
4. SOCIAL SECURITY NUMBER 579-40-3286		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 67 YRS.		7. DATE OF BIRTH (Month, Day, Year) Oct. 25, 1927	
8. FACILITY NAME (If not institution, give street and number) Kensington Gardens				9b. CITY, TOWN OR LOCATION OF DEATH Kensington		9c. COUNTY OF DEATH Montgomery	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Kensington		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 10820 Torrance Drive				10f. ZIP CODE 20895		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) +5		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Physician		16b. KIND OF BUSINESS/INDUSTRY Own Practice			
17. FATHER'S NAME (First, Middle, Last) James Walter Carter, II				18. MOTHER'S NAME (First, Middle, Maiden Surname) Anna Bell Cloakey			
19a. INFORMANT'S NAME (Type/Print) John H. Thomas				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7701 Trammell Road, Annandale, Virginia 22003			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Rock Creek Cemetery 4/19		20c. LOCATION — City or Town, State Washington, D.C.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John H. Thomas</i>				22. NAME AND ADDRESS OF FACILITY Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland 20904			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <i>Cerebrovascular accident</i> DUE TO (OR AS A CONSEQUENCE OF):				Approximate Interval Between Onset and Death <i>1 hr.</i>	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST		b. <i>Cerebral arteriosclerosis</i> DUE TO (OR AS A CONSEQUENCE OF):				2 hrs.	
		c. _____ DUE TO (OR AS A CONSEQUENCE OF):					
		d. _____ DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
				28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Joseph J. Wallace M.D.</i>				29c. LICENSE NUMBER D-11031		29d. DATE SIGNED (Month, Day, Year) 4/16/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Joseph J. Wallace, M.D. 5272 River Road, #340, Bethesda, Maryland 20816							
31. DATE FILED (Month, Day, Year) APR 21 1995				32. REGISTRAR'S SIGNATURE <i>John H. Thomas</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13706

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Kathleen Blythe Craig</i>				2. DATE OF DEATH MONTH <i>April</i> DAY <i>19</i> YEAR <i>95</i>		3. TIME OF DEATH <i>8:00 A.M.</i>	
4. SOCIAL SECURITY NUMBER <i>217-42-8605</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <i>49</i> YRS.	7. DATE OF BIRTH (Month, Day, Year) <i>Nov. 22, 1945</i>		8. BIRTHPLACE (State or Foreign Country) <i>Washington, DC</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>4111 Postgate Terrace, Apt. 202</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Silver Spring</i>		9c. COUNTY OF DEATH <i>Montgomery</i>	
10a. STATE <i>Maryland</i>				10b. COUNTY <i>Montgomery</i>		10c. CITY, TOWN OR LOCATION <i>Silver Spring</i>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER <i>4111 Postgate Terrace, Apt. 202</i>				10f. ZIP CODE <i>20906</i>		10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <i>Elementary/Secondary (0-12)</i> <i>12</i>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Teller</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Banking</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Earl Mitchell Craig, Sr.</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Esther R. Adsit</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Esther R. Verhelst</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>4111 Postgate Terrace, Apt. 202, Silver Spring, MD 20906</i>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Metropolitan Crematory 4/20/95</i>		20c. LOCATION — City or Town, State <i>Alexandria, VA</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Robert E. Ramsey</i>				22. NAME AND ADDRESS OF FACILITY <i>Francis J. Collins Funeral Home, Inc. 500 University Blvd. W. Sil. Spr. MD 20901</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Diabetes mellitus</i> Due TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Due TO (OR AS A CONSEQUENCE OF): Due TO (OR AS A CONSEQUENCE OF): Due TO (OR AS A CONSEQUENCE OF): Due TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John T. [Signature]</i>				29c. LICENSE NUMBER <i>D08546</i>		29d. DATE SIGNED (Month, Day, Year) <i>April 19 95</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>John T. [Signature] 8218 W. [Address] Ave Bethesda Md.</i>							
31. DATE FILED (Month, Day, Year) <i>APR 21 1995</i>				32. REGISTRAR'S SIGNATURE <i>John T. [Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

REVCH FOMID

2nd 11/24 4th 1/24

11

REVCH FOMID

95 13707

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) <i>Audrey Clarice Carl</i>				2. DATE OF DEATH MONTH <i>April</i> DAY <i>9</i> YEAR <i>1995</i>		3. TIME OF DEATH <i>2:45</i> M	
4. SOCIAL SECURITY NUMBER <i>220-10-3255</i>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) <i>74</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>Dec. 20, 1920</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Washington County Hospital</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Hagerstown</i>		9c. COUNTY OF DEATH <i>Washington</i>	
10a. STATE <i>Md.</i>				10b. COUNTY <i>Washington</i>		10c. CITY, TOWN OR LOCATION <i>Smithsburg</i>	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <i>120 Water St. West</i>		10f. ZIP CODE <i>21783</i>	
10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>				11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>		15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i></i>	
16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Homemaker</i>				16b. KIND OF BUSINESS/INDUSTRY <i>Home</i>		17. FATHER'S NAME (First, Middle, Last) <i>Samuel H. Dayton</i>	
18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Bessie M. Accord</i>				19a. INFORMANT'S NAME (Type/Print) <i>Joyce K. Kindle</i>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>13135 Goldizen Lane Clear Spring, Md. 21722</i>	
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Rest Haven Cemetery 4-12-95</i>		20c. LOCATION — City or Town, State <i>Hagerstown, Md.</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSE <i>Pennis L. Davis</i>				22. NAME AND ADDRESS OF FACILITY <i>Davis Funeral Home 12525 Bradbury Ave. Smithsburg, Md. 21783</i>		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>pneumonia</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Gangrene left foot, Right finger Hypertension congestive heart failure</i>				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined	
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. DESCRIBE HOW INJURY OCCURRED		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>Glenn J. Pura M.D.</i>		29c. LICENSE NUMBER <i>D19824</i>	
29d. DATE SIGNED (Month, Day, Year) <i>4/10/95</i>				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>GLORIA F. PURA MD 366 Mill St. Hagerstown MD 21740</i>		31. DATE FILED (Month, Day, Year) <i>APR 12 1995</i>	
32. REGISTRAR'S SIGNATURE <i>John D. R. R. R.</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13708

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>HILDA L. CARPER</u>				2. DATE OF DEATH MONTH <u>April</u> DAY <u>16</u> YEAR <u>1995</u>				3. TIME OF DEATH <u>1135 A M</u>					
4. SOCIAL SECURITY NUMBER <u>220-16-2796</u>				5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>88</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>4-8-1907</u>		8. BIRTHPLACE (State or Foreign Country) <u>Pennsylvania</u>			
9a. FACILITY NAME (If not institution, give street and number) <u>Washington County Hospital</u>						9b. CITY, TOWN OR LOCATION OF DEATH <u>Hagerstown</u>				9c. COUNTY OF DEATH <u>Washington</u>			
10a. STATE <u>Maryland</u>				10b. COUNTY <u>Washington</u>				10c. CITY, TOWN OR LOCATION <u>Hagerstown</u>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <u>20102 Jefferson Blvd.</u>						10f. ZIP CODE <u>21742</u>				10g. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yea or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <u>White</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>8 years</u> College (1-4 or 5+) <u></u>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Homemaker</u>				16b. KIND OF BUSINESS/INDUSTRY <u>Personal Residence</u>					
17. FATHER'S NAME (First, Middle, Last) <u>George Knepper</u>						18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Agnes K. Bumbaugh</u>							
19a. INFORMANT'S NAME (Type/Print) <u>C. Lee Lecron</u>						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>20113 Trovinger Mill Road Hagerstown, Md. 21742</u>							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Mt. Zion Cemetery 4-19-1995</u>				20c. LOCATION — City or Town, State <u>Quincy, Pennsylvania</u>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Douglas A. Fiery</u>						22. NAME AND ADDRESS OF FACILITY <u>Douglas A. Fiery Funeral Home 1331 Eastern Blvd. Hagerstown, Maryland</u>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>PNEUMONIA</u> DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death <u>10 DAYS</u> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>ATHEROSCLEROTIC HEART DISEASE WITH CORONARY CIRCULATION</u> <u>CARDIAC FAILURE</u> DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1a <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year) <u>NONE</u>		28b. TIME OF INJURY <u>M</u>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28i. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER <u>[Signature]</u>						29c. LICENSE NUMBER <u>DD1040</u>				29d. DATE SIGNED (Month, Day, Year) <u>04-16-95</u>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>BARRY M. COHEN, MD, 18706 CHATEAU DR, HAGERSTOWN, MD 21742</u>													
31. DATE FILED (Month, Day, Year) <u>APR 18 1995</u>				32. REGISTRAR'S SIGNATURE <u>[Signature]</u>									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13709

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Lionel Kenneth L. Cornwell				2. DATE OF DEATH MONTH DAY YEAR April 13 1995		3. TIME OF DEATH 9:40P	
4. SOCIAL SECURITY NUMBER 230-56-3331		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		8. AGE (In yrs. last birthday) 90 YRS.		7. DATE OF BIRTH (Month, Day, Year) March 27 1905	
9a. FACILITY NAME (If not institution, give street and number) Ginger Cove Health Center		9b. CITY, TOWN OR LOCATION OF DEATH Annapolis		9c. COUNTY OF DEATH Anne Arundel			
10a. STATE MD		10b. COUNTY Anne Arundel		10c. CITY, TOWN OR LOCATION Annapolis		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 1104 River Crescent Drive		10f. ZIP CODE 21401		10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Civil Service		16b. KIND OF BUSINESS/INDUSTRY Department of Army			
17. FATHER'S NAME (First, Middle, Last) Elmer G. Cornwell				18. MOTHER'S NAME (First, Middle, Maiden Surname) Grace D. McConnell			
19a. INFORMANT'S NAME (Type/Print) Jean M. Cornwell				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1104 River Crescent Drive Annapolis, MD 21401			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) St. Pauls United Methodist Cem 4/18/95		20c. LOCATION — City or Town, State Lusby, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Donald S. Taylor</i>				22. NAME AND ADDRESS OF FACILITY John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Chronic obstructive pulmonary disease DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death many years Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Charles W. Kinzer</i>				29c. LICENSE NUMBER D05928		29d. DATE SIGNED (Month, Day, Year) April 14, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Charles W. Kinzer MD, 1833A Forest Dr. Annapolis, MD 21401							
31. DATE FILED (Month, Day, Year) APR 19 1995		32. REGISTRAR'S SIGNATURE <i>John A. ...</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13710

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Flossie I Cromer				2. DATE OF DEATH MONTH 4 DAY 15 YEAR 95		3. TIME OF DEATH 5:20 A.M.	
4. SOCIAL SECURITY NUMBER 459-32-4298		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 79 YRS.		7. DATE OF BIRTH (Month, Day, Year) Aug 26 1915	
9a. FACILITY NAME (If not institution, give street and number) Trinity Nursing Center				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH Baltimore	
10a. STATE MD		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 2401 Gwynnoak Avenue				10f. ZIP CODE 21207		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married XX Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Home			
17. FATHER'S NAME (First, Middle, Last) Willie Rodgers				18. MOTHER'S NAME (First, Middle, Maiden Surname) Cordie D. Lewellen			
19a. INFORMANT'S NAME (Type/Print) Elizabeth Seiler				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2119 St. Lukes Ln. Baltimore, MD 21207-4470			
20a. METHOD OF DISPOSITION XX Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Conroe Memorial Gardens 4/20/95		20c. LOCATION — City or Town, State Conroe, Texas			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Wayne P. Seiler</i>				22. NAME AND ADDRESS OF FACILITY John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cardiomyopathy a. DUE TO (OR AS A CONSEQUENCE OF): b. Ischemic heart disease c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Renal failure							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>St. J. Olet, MD</i>				29c. LICENSE NUMBER 2D27211		29d. DATE SIGNED (Month, Day, Year) 4/15/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 1247 Liberty Rd Eldersburg MD 21784 Steven Bitter, MD							
31. DATE FILED (Month, Day, Year) APR 19 1995		32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13711

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JOSEPH CAGER				2. DATE OF DEATH MONTH 04 DAY 06 YEAR 95		3. TIME OF DEATH 2:35 P.M.	
4. SOCIAL SECURITY NUMBER 213-32-6622		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 57 YRS.		7. DATE OF BIRTH (Month, Day, Year) SEPT. 23 1937	
9a. FACILITY NAME (If not institution, give street and number) ANNE ARUNDEL MEDICAL CENTER				9b. CITY, TOWN OR LOCATION OF DEATH ANNAPOLIS		9c. COUNTY OF DEATH ANNE ARUNDEL	
10a. STATE MARYLAND				10b. COUNTY ANNE ARUNDEL		10c. CITY, TOWN OR LOCATION SEVERNA PARK	
10d. RESIDENCE OF DECEDENT 112 DENNIS ROAD				10e. ZIP CODE 21146		10f. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) _____		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) LABORER		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) Frank CAGER				18. MOTHER'S NAME (First, Middle, Maiden Surname) MARY JANE PACK			
19a. INFORMANT'S NAME (Type/Print) MARTHA WOODARD				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 701 GLENWOOD ST. APT. 512 ANNAPOLIS, MD. 21401			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) ASBURY TOWNECK CHURCH CEME. 4/12/95		20c. LOCATION — City or Town, State ST. MARGARETS, MDD		20d. DATE 4/12/95	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Larry B. Reese</i>				22. NAME AND ADDRESS OF FACILITY REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. Meningitis DUE TO (OR AS A CONSEQUENCE OF):				Approximate Interval Between Onset and Death weeks	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. LIVER FAILURE DUE TO (OR AS A CONSEQUENCE OF):				weeks	
		c. _____ DUE TO (OR AS A CONSEQUENCE OF):					
		d. _____ DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER 025812		29d. DATE SIGNED (Month, Day, Year) 4/7/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J. Teitelbaum 139 Old Solomons Rd Annapolis, Md 21401							
31. DATE FILED (Month, Day, Year) APR 18 1995				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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95 13712

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) HILDA COOLING				2. DATE OF DEATH MONTH DAY YEAR APRIL 14, 1995		3. TIME OF DEATH 10:15 AM	
4. SOCIAL SECURITY NUMBER 217-36-3888		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 89 YRS.		7. DATE OF BIRTH (Month, Day, Year) FEB 12, 1906	
8. BIRTHPLACE (State or Foreign Country) MARYLAND				9a. FACILITY NAME (If not institution, give street and number) MEDPOINTE, 1 PRICE DRIVE		9b. CITY, TOWN OR LOCATION OF DEATH ELKTON, MD	
9c. COUNTY OF DEATH CECIL				10a. STATE MD		10b. COUNTY Cecil	
10c. CITY, TOWN OR LOCATION Chesapeake City				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 716 Mt Nebo Rd	
10f. ZIP CODE 21915				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 1				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Teacher		16b. KIND OF BUSINESS/INDUSTRY Education	
17. FATHER'S NAME (First, Middle, Last) Ermon W. Taylor				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mattie Knowles			
19a. INFORMANT'S NAME (Type/Print) Walter F Cooling				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 716 Mt Nebo Rd Chesapeake City MD 21915			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Bethel Cmty April 17 1995		20c. LOCATION — City or Town, State Chesapeake City MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY R. T. Foard Funeral Home 318 George St Chesapeake City MD 21915			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Dilative cardiomyopathy</u> DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate Interval Between Onset and Death five	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Fractured hip-repaired Massive CVA with left hemiplegia atrial fibrillation, Osteoarthritis severe Gastropathy with bleeding.</u>						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO						25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)	
28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <u>Wallace Obenshain M.D.</u>		29c. LICENSE NUMBER D-07129	
29d. DATE SIGNED (Month, Day, Year) Apr 14, 1995		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Wallace Obenshain, MD, Cecil, MD.		31. DATE FILED (Month, Day, Year) APR 18 1995		32. REGISTRAR'S SIGNATURE <u>Julia Davidson Randall</u>	

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.


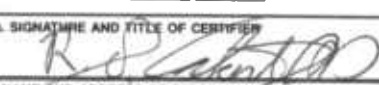
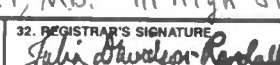
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

[Handwritten signature]

95 13713

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Carolyn Trump Clark				2. DATE OF DEATH MONTH DAY YEAR April 8, 1995				3. TIME OF DEATH 3:50 P. M.		
4. SOCIAL SECURITY NUMBER 199-07-3308		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 73 YRS.	7. DATE OF BIRTH (Month, Day, Year) May 2, 1921		8. BIRTHPLACE (State or Foreign Country) Pennsylvania				
9a. FACILITY NAME (If not institution, give street and number) 12 Park Lane				9b. CITY, TOWN OR LOCATION OF DEATH Elkton			9c. COUNTY OF DEATH Cecil			
RESIDENCE OF DECEDENT										
10a. STATE Maryland		10b. COUNTY Cecil		10c. CITY, TOWN OR LOCATION Elkton			10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 12 Park Lane				10f. ZIP CODE 21921		10g. CITIZEN OF WHAT COUNTRY? United States				
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker			16b. KIND OF BUSINESS/INDUSTRY Her Own Home			
17. FATHER'S NAME (First, Middle, Last) Admiral Trump				18. MOTHER'S NAME (First, Middle, Maiden Surname) Pearl Yost						
19a. INFORMANT'S NAME (Type/Print) Stanley E. Clark, Sr.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 125 Whitmore Drive, Elkton, MD 21921						
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) North East Methodist Cem. 4/12			20c. LOCATION — City or Town, State North East, Maryland					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Crouch Funeral Home 127 South Main Street, North East Md 21901						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Interstitial Pulmonary Fibrosis</u> DUE TO (OR AS A CONSEQUENCE OF): Sequently ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. _____ DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____									Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>										
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D30055		29d. DATE SIGNED (Month, Day, Year) 4-11-95				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Richard S. Ackart, MD, 111 High St. Suite 103 Elkton, MD 21921-5565										
31. DATE FILED (Month, Day, Year) APR 12 1995		32. REGISTRAR'S SIGNATURE 								

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13714

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) John Edward Chesley				2. DATE OF DEATH April 17 1995		3. TIME OF DEATH 6:34 A	
4. SOCIAL SECURITY NUMBER 217-18-2269		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 75 YRS.		7. DATE OF BIRTH (Month, Day, Year) FEB. 14, 1920	
8. BIRTHPLACE (State or Foreign Country) MARYLAND		9a. FACILITY NAME (If not Institution, give street and number) Physicians Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH LaPlata		9c. COUNTY OF DEATH Charles	
10a. STATE MARYLAND				10b. COUNTY CHARLES		10c. CITY, TOWN OR LOCATION MARSHALL'S CORNER	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER #7750 HAWTHORNE ROAD		10f. ZIP CODE 20646	
10g. CITIZEN OF WHAT COUNTRY? UNITED STATES				11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: BLACK		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6TH GRADE College (1-4 or 5+) College (1-4 or 5+)	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) MECHANIC				16b. KIND OF BUSINESS/INDUSTRY AUTOMOBILES		17. FATHER'S NAME (First, Middle, Last) BERNARD SYLVESTER CHESLEY	
18. MOTHER'S NAME (First, Middle, Maiden Surname) ELENORE WADE HILL CHESLEY				19a. INFORMANT'S NAME (Type/Print) LLOYD E. CHESLEY		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) #9502 PIN OAK STREET, CLINTON, MARYLAND 20735	
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) ST. JOSEPH'S CHURCH CEM. 4/21/95		20c. LOCATION — City or Town, State POMFRET, MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Lydia C. Thornton Johnson LYDIA C. THORNTON JOHNSON MO0583				22. NAME AND ADDRESS OF FACILITY THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MD. 20640			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. SEPSIS DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { b. AZOTEMIA c. DEHYDRATION d. } Approximate Interval Between Onset and Death 24 HR 48-72 HRS 48-72 HRS							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CARDIAC ARRHYTHMIA							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO NA			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) NA		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED NA		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) NA		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) NA			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Ashvinkumar Patel, MD				29c. LICENSE NUMBER D-44436		29d. DATE SIGNED (Month, Day, Year) 4/17/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Ashvinkumar Patel, Md 603 Post Office Road Suite 207 Waldorf, MD 20602							
31. DATE FILED (Month, Day, Year) APR 19 1995				32. REGISTRAR'S SIGNATURE John A. Hendry			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13715

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) CHARLES EDWARD COMPTON				2. DATE OF DEATH MONTH APRIL DAY 8 YEAR 1995		3. TIME OF DEATH 3:35P	
4. SOCIAL SECURITY NUMBER 212-30-3329		5. SEX 1 M 2 F	6. AGE (In yrs. last birthday) 66 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 1/8/29	
9a. FACILITY NAME (If not institution, give street and number) VAMC, FORT HOWARD, MD. 21052				9b. CITY, TOWN OR LOCATION OF DEATH Fort Howard		9c. COUNTY OF DEATH Baltimore	
10a. STATE Maryland				10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Monkton	
10d. INSIDE CITY LIMITS? 1 YES 2 X NO				10e. STREET AND NUMBER 16306 Old York Road			
10f. ZIP CODE 2111				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 Never Married 2 Married 3 X Widowed 4 Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 X NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Caucasian	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 2		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Contractor		16b. KIND OF BUSINESS/INDUSTRY Construction			
17. FATHER'S NAME (First, Middle, Last) Hollyday Sothern Compton				18. MOTHER'S NAME (First, Middle, Maiden Surname) Elizabeth Griswold Phelps			
19a. INFORMANT'S NAME (Type/Print) Hollyday Phelps Compton				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26 Chauncey St. #5 Cambridge, Mass. 02138			
20a. METHOD OF DISPOSITION 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Carroll Cremation		20c. LOCATION — City or Town, State Hampstead, Maryland		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>M. Bladen Kurtz</i>				22. NAME AND ADDRESS OF FACILITY Kurtz Funeral Home Jarrettsville, Maryland			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → ALCOHOL ABUSE Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. PNEUMONIA c. SEPSIS d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO				28. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify)			
27. MANNER OF DEATH 1 X Natural 5 Pending Investigation 2 Accident 3 Suicide 4 Homicide 6 Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 YES 2 NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 X CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John A. Anderson-Randall</i>				29c. LICENSE NUMBER D 45708		29d. DATE SIGNED (Month, Day, Year) 4/8/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) RAUL RIVERA, M.D., 9600 NORTH POINT ROAD, FORT HOWARD, MD. 21052							
31. DATE FILED (Month, Day, Year) APR 12 1995				32. REGISTRAR'S SIGNATURE <i>John A. Anderson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) Jeffrey Leo Ciemny				2. DATE OF DEATH MONTH DAY YEAR April 10 1995		3. TIME OF DEATH 0135 M					
4. SOCIAL SECURITY NUMBER 215-74-5110		5. SEX 1 <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 38 YRS.		7. DATE OF BIRTH (Month, Day, Year) March 8, 1957		8. BIRTHPLACE (State or Foreign Country) Maryland			
9a. FACILITY NAME (If not institution, give street and number) 9528 Perryhall Blvd., Apt 104				9b. CITY, TOWN OR LOCATION OF DEATH Perryhall			9c. COUNTY OF DEATH Baltimore				
10a. STATE Maryland		10b. COUNTY Harford		10c. CITY, TOWN OR LOCATION Bel Air			10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				
10e. STREET AND NUMBER 820 Dora Place				10f. ZIP CODE 21014		10g. CITIZEN OF WHAT COUNTRY? USA					
11. MARITAL STATUS 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Medical Technologist			16b. KIND OF BUSINESS/INDUSTRY Medical						
17. FATHER'S NAME (First, Middle, Last) Sylvester --- Ciemny				18. MOTHER'S NAME (First, Middle, Maiden Surname) Catherine Adella Graziano							
19a. INFORMANT'S NAME (Type/Print) Susan J. Ciemny				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 820 Dora Place, Bel Air, Md. 21014							
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) R. A. Ferris & Co. 4-13-95		20c. LOCATION — City or Town, State W. Chester, Pa.							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Howard K. McComas III</i>				22. NAME AND ADDRESS OF FACILITY Howard K. McComas III Funeral Home, P.A. 50 W. Broadway St., Bel Air, Md. 21014							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Intraoral gunshot wound DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) at scene									
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) Found 4/9/95		28b. TIME OF INJURY 2350HRS		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED subject shot self			
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) residence		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 9528 Perry Hall Boulevard Apartment 104							
29a. CERTIFIER (Check only one) 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Theodore M. K...</i>						29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) April 10 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) THEODORE M. K... 111 Penn Street, Baltimore Maryland 21201											
31. DATE FILED (Month, Day, Year) APR 12 1995		32. REGISTRAR'S SIGNATURE <i>John Andrew Randall</i>									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13717

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) CON-PABLO CARREON-KNABLE				2. DATE OF DEATH MONTH APRIL DAY 18 YEAR 1995		3. TIME OF DEATH 8:55 a M	
4. SOCIAL SECURITY NUMBER NONE		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		8. AGE (In yrs. last birthday) YRS. MONTHS 1 DAYS 18		7. DATE OF BIRTH (Month, Day, Year) March 1, 1995	
9a. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY		9c. COUNTY OF DEATH MD	
10a. STATE MD		10b. COUNTY Washington		10c. CITY, TOWN OR LOCATION Hancock		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 8707 Corner Road				10f. ZIP CODE 21750		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 0		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) None		16b. KIND OF BUSINESS/INDUSTRY NONE			
17. FATHER'S NAME (First, Middle, Last) Dale Eugene Knable				18. MOTHER'S NAME (First, Middle, Maiden Surname) Lucia Manalili Carreon			
19a. INFORMANT'S NAME (Type/Print) Dale E. Knable				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8707 Corner RD Hancock, MD 21750			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Orchard Ridge Cem. 4/20/95		20c. LOCATION — City or Town, State Hancock, MD		22. NAME AND ADDRESS OF FACILITY Grove Funeral Home P.O. Box 368 Hancock, MD 21750	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY Grove Funeral Home P.O. Box 368 Hancock, MD 21750			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Necrotizing Enterocolitis DUE TO (OR AS A CONSEQUENCE OF): b. Extreme Prematurity DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death 24 hours 48 days
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIC, SEPSIS, INTRAVENTRICULAR HEMORRHAGE							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE NOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER Bertha Kao-Mup NEONATAL Fellow		29c. LICENSE NUMBER M8424		29d. DATE SIGNED (Month, Day, Year) April 18, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) BERTHA KAO CMSC #210 600 N WOLFE ST BALTIMORE MD 21205							
31. DATE FILED (Month, Day, Year) APR 28 1995		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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95 13718

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ONEDA MARIE DAVIS				2. DATE OF DEATH MONTH DAY YEAR APRIL 20, 1995		3. TIME OF DEATH 1:30 P M	
4. SOCIAL SECURITY NUMBER 214-03-5679		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 77 YRS.		7. DATE OF BIRTH (Month, Day, Year) AUG 29, 1917	
9a. FACILITY NAME (If not institution, give street and number) GARRETT COUNTY MEMORIAL HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH OAKLAND		9c. COUNTY OF DEATH GARRETT	
10a. STATE MARYLAND				10b. COUNTY GARRETT		10c. CITY, TOWN OR LOCATION OAKLAND	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER 12 N. WILSON STREET			
10f. ZIP CODE 21550				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER		16b. KIND OF BUSINESS/INDUSTRY OWN HOME			
17. FATHER'S NAME (First, Middle, Last) WILLIAM AMOS JOHNSON, SR.				18. MOTHER'S NAME (First, Middle, Maiden Surname) EMMA FAYE RICE			
19a. INFORMANT'S NAME (Type/Print) INEZ GRIFFITHS				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3506 CHARLESTON LN. CIBOLO, TX 78108			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) OAKLAND CEMETERY		OATE 4/23		20c. LOCATION — City or Town, State OAKLAND, MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE MO0167				22. NAME AND ADDRESS OF FACILITY P.O. BOX 243 DURST FUNERAL HOME - OAKLAND, MD 21550			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cerebrovascular Accident DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office, building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D23979		29d. DATE SIGNED (Month, Day, Year) 4/24/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ROBERT A. GORALSKI, M.D. 311 N. 4TH ST. OAKLAND, MARYLAND 21550							
31. DATE FILED (Month, Day, Year) APR 24 1995		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

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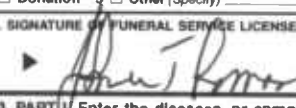
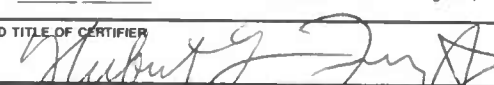
95 13719

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) HELEN LOUISE DAIL				2. DATE OF DEATH MONTH April DAY 14 YEAR 1995		3. TIME OF DEATH 3:45 M	
4. SOCIAL SECURITY NUMBER 214-07-9699		5. SEX 1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 94 YRS.		7. DATE OF BIRTH (Month, Day, Year) Dec. 8 1900	
9a. FACILITY NAME (If not institution, give street and number) Dorchester General Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Cambridge		9c. COUNTY OF DEATH Dorchester	
10a. STATE Maryland		10b. COUNTY Dorchester		10c. CITY, TOWN OR LOCATION Cambridge		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 317 Mill St.				10f. ZIP CODE 21613		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) 11		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) homemaker		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) William S. Cannon				18. MOTHER'S NAME (First, Middle, Maiden Surname) Lula Condon			
19a. INFORMANT'S NAME (Type/Print) Marian C. Dail				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 317 Mill St., Cambridge Md. 21613			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Cambridge Cemetery		DATE 4/18		20c. LOCATION — City or Town, State Cambridge Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Thomas Funeral Home 700 Locust St. Cambridge MD 21613			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Congestive Heart Failure DUE TO (OR AS A CONSEQUENCE OF): b. Arteriosclerotic Cardiovascular Disease DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							Approximate interval Between Onset and Death days years
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Pneumonia Severe Rheumatoid Arthritis, Advanced Age DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER DM 773		29d. DATE SIGNED (Month, Day, Year) APRIL 14, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Hubert L. Fiery, M.D. 503 Byrn Street Cambridge, MD 21613							
31. DATE FILED (Month, Day, Year) APR 19 1995							

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

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95 13720

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>HELEN J. DARLING</i>				2. DATE OF DEATH MONTH <i>APRIL</i> DAY <i>14</i> YEAR <i>95</i>		3. TIME OF DEATH <i>2:20 P.M.</i>	
4. SOCIAL SECURITY NUMBER <i>264-52-0544</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>85</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>July 3, 1909</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Randolph Hills Nursing Home</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Silver Spring</i>		9c. COUNTY OF DEATH <i>Montgomery</i>	
10a. STATE <i>Maryland</i>				10b. COUNTY <i>Montgomery</i>		10c. CITY, TOWN OR LOCATION <i>Silver Spring</i>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <i>15201 Elkridge Way #1-C</i>			
10f. ZIP CODE <i>20906</i>				10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>6</i> College (1-4 or 5+) <i>College (1-4 or 5+)</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Clerk</i>		16b. KIND OF BUSINESS/INDUSTRY <i>U.S. Government</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Thomas H. Johnson</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Mary B. Harris</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Evelyn I. Johnson</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>15201 Elkridge Way #1-C Silver Spring, MD 20906</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>St. Mary's Cemetery 4/18/95</i>		20c. LOCATION — City or Town, State <i>Washington, D.C.</i>		20d. DATE <i>4/18/95</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Steven J. Stroud</i>				22. NAME AND ADDRESS OF FACILITY <i>Francis J. Collins Funeral Home, Inc. 500 University Blvd.W. Sil.Spr.MD 20901</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>a. Acute myocardial infarction</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>b. DUE TO (OR AS A CONSEQUENCE OF):</i> <i>c. DUE TO (OR AS A CONSEQUENCE OF):</i> <i>d. DUE TO (OR AS A CONSEQUENCE OF):</i>							Approximate Interval Between Onset and Death <i>1 day</i>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Prophylactic leucemia & lymphoma</i>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Barry Rosenbaum</i>				29c. LICENSE NUMBER <i>009834</i>		29d. DATE SIGNED (Month, Day, Year) <i>4/15/95</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>BARRY ROSENBAUM 3720 FARRAGUT AVE KENSINGTON, MD</i>							
31. DATE FILED (Month, Day, Year) <i>APR 19 1995</i>		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Rodell</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

68760

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.


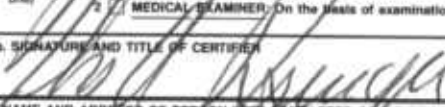
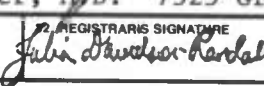
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13721

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Joan Marie Dunn				2. DATE OF DEATH MONTH DAY YEAR APRIL 17 1995				3. TIME OF DEATH 10:30 A.M.	
4. SOCIAL SECURITY NUMBER 577-36-5491		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 64 YRS.	7. DATE OF BIRTH (Month, Day, Year) May 7, 1930		8. BIRTHPLACE (State or Foreign Country) Washington, DC			
9a. FACILITY NAME (If not institution, give street and number) 9316 Edmonston Rd., #101				9b. CITY, TOWN OR LOCATION OF DEATH Greenbelt			9c. COUNTY OF DEATH Prince Georges		
10a. STATE Maryland		10b. COUNTY Prince Georges		10c. CITY, TOWN OR LOCATION Greenbelt			10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		
10e. STREET AND NUMBER 9316 Edmonston Road #101				10f. ZIP CODE 20770		10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Instructional Assistant			16b. KIND OF BUSINESS/INDUSTRY Special Education				
17. FATHER'S NAME (First, Middle, Last) William Wallace Hughes				18. MOTHER'S NAME (First, Middle, Maiden Surname) Margaret Opal Thompson					
19a. INFORMANT'S NAME (Type/Print) Kevin P. Dunn				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1703 Wickham Way Crofton, MD 21114					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gate of Heaven Cemetery 4/20/95			20c. LOCATION — City or Town, State Silver Spring, MD				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, INC. 500 University Blvd.W. Sil.Spr.MD 20901					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Superior Vena Cava Syndrome DUE TO (OR AS A CONSEQUENCE OF): Metastatic Squamous Cell Lung Cancer Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death 2 mos. 8 mos.	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DCA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER D08754		29d. DATE SIGNED (Month, Day, Year) April 19, 1995			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Thomas A. Bensinger, M.D. 7525 Greenway Center Dr. Suite 205 Greenbelt, MD 20770									
31. DATE FILED (Month, Day, Year) APR 20 1995				32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

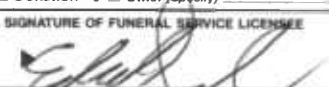
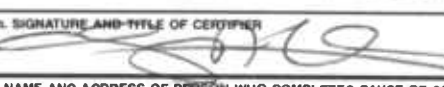

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13722

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Beverly Brown Davis				2. DATE OF DEATH MONTH DAY YEAR April 15 1995		3. TIME OF DEATH 5:05 P. M	
4. SOCIAL SECURITY NUMBER 220-34-4258		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 56 YRS.		7. DATE OF BIRTH (Month, Day, Year) Dec 28 1938	
9a. FACILITY NAME (If not institution, give street and number) 13110 Old Fletchertown Road				9b. CITY, TOWN OR LOCATION OF DEATH Bowie		9c. COUNTY OF DEATH Prince George	
RESIDENCE OF DECEDENT							
10a. STATE MD		10b. COUNTY Prince George		10c. CITY, TOWN OR LOCATION Bowie		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 13110 Old Fletchertown Road				10f. ZIP CODE 20720		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMY FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Office Manager		16b. KIND OF BUSINESS/INDUSTRY Space Industry			
17. FATHER'S NAME (First, Middle, Last) Meyer Brown				18. MOTHER'S NAME (First, Middle, Maiden Surname) Bertha Walcoff			
19a. INFORMANT'S NAME (Type/Print) Ilana Forsythe				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4437 Cape Cod Circle Bowie MD 20720			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Menorah Gardens		20c. LOCATION — City or Town, State 4-18 Rockville MD		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY EDWARD SAGEL FUNERAL DIRECTION 1091 Rockville Pike Rockville MD 20852			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Giant Cell Carcinoma of Lung DUE TO (OR AS A CONSEQUENCE OF): Smoking Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. Smoking DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate interval Between Onset and Death 3 mo years							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24e. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER 086199		29d. DATE SIGNED (Month, Day, Year) 4/17/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Emily A Ulmer MD 1657 Crofton Blvd Crofton Maryland							
31. DATE FILED (Month, Day, Year) APR 21 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13723

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Paul A DeViney</i>				2. DATE OF DEATH MONTH DAY YEAR <i>April 19, 1995</i>		3. TIME OF DEATH HOURS MIN. <i>06:15 A M</i>	
4. SOCIAL SECURITY NUMBER <i>219-64-7111</i>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>40</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>Oct 26, 1954</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Montgomery General Hospital</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Olney</i>		9c. COUNTY OF DEATH <i>Montgomery</i>	
10a. STATE <i>Maryland</i>		10b. COUNTY <i>Montgomery</i>		10c. CITY, TOWN OR LOCATION <i>Brookville</i>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <i>2600 Triadelphia Lake Road</i>				10f. ZIP CODE <i>20833</i>		10g. CITIZEN OF WHAT COUNTRY? <i>United States</i>	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>1</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Hairdresser</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Beauty Salon</i>			
17. FATHER'S NAME (First, Middle, Last) <i>E. Edward Rizzo</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Joyce N. DeViney</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Joyce N. Rizzo (Mother)</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>Same as #10</i>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Chesapeake Crematory</i>		DATE <i>4/20</i>		20c. LOCATION — City or Town, State <i>Beltsville, MD</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> M00827				22. NAME AND ADDRESS OF FACILITY <i>Rapp Funeral Services, P.A. 933 Gist Ave, Silver Spring, MD 20910</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Pneumonia</i> DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>Acquired Immune Deficiency Syndrome</i> DUE TO (OR AS A CONSEQUENCE OF): Approximate interval between Onset and Death <i>Days - 5-10 Weeks - 10-20 Months - 5-10</i>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Mycobacterium Avium Intracellulare</i>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY H M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Lo Paul Kropf MD</i>				29c. LICENSE NUMBER <i>021435</i>		29d. DATE SIGNED (Month, Day, Year) <i>April 19, 1995</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Lo Paul Kropf MD 2101 Medical Park Dr Silver Spring, Md 20910</i>							
31. DATE FILED (Month, Day, Year) <i>APR 21 1995</i>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13724

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ORESSIE VIRGINIA DAVIS				2. DATE OF DEATH MONTH DAY YEAR April 23 1995		3. TIME OF DEATH 2145 M	
4. SOCIAL SECURITY NUMBER 214-09-5366		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 81 YRS.		7. DATE OF BIRTH (Month, Day, Year) AUGUST 31, 1913	
9a. FACILITY NAME (If not institution, give street and number) WASHINGTON COUNTY HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH HAGERSTOWN		9c. COUNTY OF DEATH WASHINGTON	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY WASHINGTON		10c. CITY, TOWN OR LOCATION HAGERSTOWN		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 7 EAST WASHINGTON STREET				10f. ZIP CODE 21740		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) COOK		16b. KIND OF BUSINESS/INDUSTRY HOSPITAL	
17. FATHER'S NAME (First, Middle, Last) WILLIAM OLIVER NORRIS				18. MOTHER'S NAME (First, Middle, Maiden Surname) CHARITY ANN STEELE			
19a. INFORMANT'S NAME (Type/Print) CRAIG C. MILLER				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 331 SOUTH CANNON AVENUE, HAGERSTOWN, MD. 21740			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) CEDAR LAWN MEMORIAL PARK 04-28-95		20c. LOCATION — City or Town, State HAGERSTOWN, MARYLAND		20d. DATE 04-28-95	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE R. Noel Brady				22. NAME AND ADDRESS OF FACILITY ANDREW K. COFFMAN FUNERAL HOME, INC. 40 EAST ANTIETAM ST., HAGERSTOWN, MD. 21740			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. Cardiopulmonary Arrest					
		b. Myocardial Infarction					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST		c. 					
		d. 					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Francisco L. Andrade M.D.				29c. LICENSE NUMBER D27898		29d. DATE SIGNED (Month, Day, Year) 4/24/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) FRANCISCO L. ANDRADE 350 MILL ST. HAGERSTOWN, MD							
31. DATE FILED (Month, Day, Year) APR 27 1995				32. REGISTRAR'S SIGNATURE J. A. ...			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13725

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Robert Francis Dunn				2. DATE OF DEATH MONTH April DAY 18 YEAR 1995				3. TIME OF DEATH 03:52 A.M.					
4. SOCIAL SECURITY NUMBER 705-14-0129		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 73 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS. HOURS 0 MIN. 0		7. DATE OF BIRTH (Month, Day, Year) March 1, 1922		8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not institution, give street and number) Washington County Hospital						9b. CITY, TOWN OR LOCATION OF DEATH Hagerstown				9c. COUNTY OF DEATH Washington			
RESIDENCE OF DECEDENT													
10a. STATE Md.		10b. COUNTY Washington				10c. CITY, TOWN OR LOCATION Hagerstown				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 18620 Maugans Ave.						10f. ZIP CODE 21742				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Machinist				16b. KIND OF BUSINESS/INDUSTRY Railroad					
17. FATHER'S NAME (First, Middle, Last) Peter Francis Dunn						18. MOTHER'S NAME (First, Middle, Maiden Surname) Myrtle Kitson							
19a. INFORMANT'S NAME (Type/Print) Robert L. Dunn						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 187 U.S. Silica Berkeley Springs, WV. 25411							
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Smithsburg Crematory 4-19-95				DATE		20c. LOCATION — City or Town, State Smithsburg, Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Hennis R. Davis						22. NAME AND ADDRESS OF FACILITY Davis Funeral Home 12525 Bradbury Ave. Smithsburg, Md. 21783							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Carcinoma of Esophagus DUE TO (OR AS A CONSEQUENCE OF): With obstruction and Aorta Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST and Trachea invasion												Approximate interval Between Onset and Death 6 mo	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.													
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO									
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER WMD						29c. LICENSE NUMBER D18127				29d. DATE SIGNED (Month, Day, Year) 4/18/95			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) C.C. Sullivan MD 370 Mill St. Hagerstown Md 21740													
31. DATE FILED (Month, Day, Year) APR 20 1995				32. REGISTRAR'S SIGNATURE Johi Anderson									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13726

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Nina DeLauter</i>				2. DATE OF DEATH MONTH <i>April</i> DAY <i>15</i> YEAR <i>1995</i>		3. TIME OF DEATH <i>0500 A M</i>	
4. SOCIAL SECURITY NUMBER <i>220-16-1090</i>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <i>73</i> YRS.	7. DATE OF BIRTH (Month, Day, Year) <i>Oct. 29, 1921</i>		8. BIRTHPLACE (State or Foreign Country) <i>Maryland</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>15629 Quirauk School Rd.</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Sabillasville</i>		9c. COUNTY OF DEATH <i>Frederick</i>	
RESIDENCE OF DECEDENT							
10a. STATE <i>Md.</i>		10b. COUNTY <i>Frederick</i>		10c. CITY, TOWN OR LOCATION <i>Sabillasville</i>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <i>15629 Quirauk School Rd.</i>				10f. ZIP CODE <i>21780</i>		10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>U.S.A</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i></i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Housewife</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Home</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Russell H. Lewis</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Hallie Tyler</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Howard L. DeLauter Sr.</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>15629 Quirauk School Rd. Sabillasville, Md. 21780</i>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Bethel Cemetery 4-18-95</i>		20c. LOCATION — City or Town, State <i>Cascade, Md.</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Pennio R. Davis</i>				22. NAME AND ADDRESS OF FACILITY <i>Davis Funeral Home 12525 Bradbury Ave. Smithsburg, Md. 21783</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>a. Carcinoma of colon</i>							
DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>George Newman M.D. Ph.D.</i>				29c. LICENSE NUMBER <i>D17591</i>		29d. DATE SIGNED (Month, Day, Year) <i>4/17/95</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>1799 Howell Rd Hagerstown, Md 21740</i>							
31. FIELD (Month, Day, Year) <i>APR 17 1995</i> REGISTRAR'S SIGNATURE <i>John D. ...</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1944-1945 1946 1947

95 13727

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARY F. DORSEY				2. DATE OF DEATH MONTH APRIL DAY 15 YEAR 1995		3. TIME OF DEATH M	
4. SOCIAL SECURITY NUMBER 214-38-8267		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 90 YRS.		7. DATE OF BIRTH (Month, Day, Year) OCT. 1 1904	
9a. FACILITY NAME (If not institution, give street and number) 2 STEPHANINE LANE				9b. CITY, TOWN OR LOCATION OF DEATH ANNAPOLIS		9c. COUNTY OF DEATH ANNE ARUNDEL	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY ANNE ARUNDEL		10c. CITY, TOWN OR LOCATION ANNAPOLIS		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 2 STEPHANINE LANE				10f. ZIP CODE 21403		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6th College (14 or 5+) HOMEMAKER				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER		16b. KIND OF BUSINESS/INDUSTRY OWN HOME	
17. FATHER'S NAME (First, Middle, Last) ALFRED ROSS				18. MOTHER'S NAME (First, Middle, Maiden Surname) ALVERTA GROSS			
19a. INFORMANT'S NAME (Type/Print) IRENE DORSEY				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 STEPHANINE LANE ANNAPOLIS, MD. 21403			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MOSES CEMETERY		DATE 4/20/95		20c. LOCATION — City or Town, State DRURY, MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Ferry H. Reese</i>				22. NAME AND ADDRESS OF FACILITY REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Dehydration a. DUE TO (OR AS A CONSEQUENCE OF): possible 2 of 2 (20-95) b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST HTN (1994) Mild Senile Dementia PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1. HTN (1994) 2. Mild Senile Dementia							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>E. H. Reese</i>				29c. LICENSE NUMBER Dop453		29d. DATE SIGNED (Month, Day, Year) 4/18/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type, Print) <i>E. H. Reese</i> 821 West St. Annapolis, MD 21401							
31. DATE FILED (Month, Day, Year) APR 18 1995				32. REGISTRAR'S SIGNATURE <i>Julia Davidson Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.



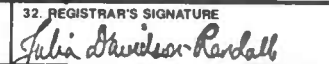
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13728

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Lillian Edelstein				2. DATE OF DEATH MONTH DAY YEAR April 19 1995		3. TIME OF DEATH a. M 6:30 a. M	
4. SOCIAL SECURITY NUMBER 076-12-2095		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 85 YRS.		7. DATE OF BIRTH (Month, Day, Year) March 1 1910	
9a. FACILITY NAME (If not institution, give street and number) Hebrew Home of Greater Washington				9b. CITY, TOWN OR LOCATION OF DEATH Rockville		9c. COUNTY OF DEATH Montgomery	
RESIDENCE OF DECEDENT							
10a. STATE MD		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Rockville		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 11801 Rockville Pike				10f. ZIP CODE 20852		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Sales Clerk		16b. KIND OF BUSINESS/INDUSTRY Candy			
17. FATHER'S NAME (First, Middle, Last) David Cohen				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ida Brown			
19a. INFORMANT'S NAME (Type/Print) Selma Kriss				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11801 Rockville Pike Rockville MD 20852			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Mt Hebron		DATE 4-20		20c. LOCATION — City or Town, State Flushing NY	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Edward Sagel Funeral Direction 1091 Rockville Pike Rockville MD 20852			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. METASTATIC CARCINOMA OF LUNG DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death 2 MONTHS
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER  Steven Lipson MD				29c. LICENSE NUMBER D 5885		29d. DATE SIGNED (Month, Day, Year) 4/19/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) STEVEN LIPSON, 6121 MONTROSE ROAD ROCKVILLE							
31. DATE FILED (Month, Day, Year) APR 21 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13729

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Bessie Mae Estep				2. DATE OF DEATH MONTH April DAY 22 YEAR 1995		3. TIME OF DEATH 9:30 A.M.	
4. SOCIAL SECURITY NUMBER 220-24-8839		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 72 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 7, 1922	
8. BIRTHPLACE (State or Foreign Country) West Virginia				9a. FACILITY NAME (If not institution, give street and number) Harford Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Havre de Grace	
9c. COUNTY OF DEATH Harford				10a. STATE Maryland		10b. COUNTY Cecil	
10c. CITY, TOWN OR LOCATION North East				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 201 Mechanics Valley Road	
10f. ZIP CODE 21901				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) Five Years College (1-4 or 5+) -----				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY -----	
17. FATHER'S NAME (First, Middle, Last) Garfield Montgomery				18. MOTHER'S NAME (First, Middle, Maiden Surname) Rosetta Phillips			
19a. INFORMANT'S NAME (Type/Print) Carolyn M. McKinney				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 201 Mechanics Valley Rd., North East, Maryland 21901			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Culpeper National Cemetery 4/25/95 Culpeper, Virginia		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Thomas M. Patterson, Sr.				22. NAME AND ADDRESS OF FACILITY Lee A. Patterson & Son Funeral Home Perryville, Maryland			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Lung Cancer resp. failure. Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. Lung Cancer resp. failure. b. Antenoprotective Cardiovascular c. COPD d. Cardiac arrhythmia							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER J. T. Lee M.D.				29c. LICENSE NUMBER 120661		29d. DATE SIGNED (Month, Day, Year) 4/23/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J. T. Lee M.D. 307 S. Union Ave Havre de Grace M.D.							
31. DATE FILED (Month, Day, Year) APR 24 1995				32. REGISTRAR'S SIGNATURE John Davidson Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

REGISTRAR				REG. NO.							
1. DECEDENT'S NAME (First, Middle, Last) gilbert ransom edwards				2. DATE OF DEATH MONTH DAY YEAR april 16 1995				3. TIME OF DEATH 1622 M			
4. SOCIAL SECURITY NUMBER 177-34-9535		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 54 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) sep 15, 1940		8. BIRTHPLACE (State or Foreign Country) Pennsylvania			
9a. FACILITY NAME (If not institution, give street and number) union hospital				9b. CITY, TOWN OR LOCATION OF DEATH elkton				9c. COUNTY OF DEATH cecil			
RESIDENCE OF DECEDENT											
10a. STATE MD		10b. COUNTY Cecil		10c. CITY, TOWN OR LOCATION Chesapeake City				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER 24 Maryland Ave Hollywood Beach				10f. ZIP CODE 21915		10g. CITIZEN OF WHAT COUNTRY? USA					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College (1-4 or 5+)			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Salesman			16b. KIND OF BUSINESS/INDUSTRY Automobile					
17. FATHER'S NAME (First, Middle, Last) Heath A. Edwards				18. MOTHER'S NAME (First, Middle, Maiden Surname) Nannie Cox							
19a. INFORMANT'S NAME (Type/Print) Connie L. Edwards				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24 Maryland Ave Hollywood Beach Chesapeake City MD 21915							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Oxford Cemetery Apr 19 1995		DATE Apr 19 1995		20c. LOCATION — City or Town, State Oxford PA					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY R. T. Foard Funeral Home 318 George St Chesapeake City MD 21915							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. asystole DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. ascd DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate interval Between Onset and Death 30 min years			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER paula a. ryals, md				29c. LICENSE NUMBER d 45838			29d. DATE SIGNED (Month, Day, Year) april 16, 1995				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) p-a. ryals, md / union hospital / elkton, md 21921											
31. DATE FILED (Month, Day, Year) APR 18 1995				32. REGISTRAR'S SIGNATURE Julia Davidson-Harrell							

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within _____ hours after death. Page 6 may be retained by the hospital or attending physician.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

NAME

95 13731

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) OPAL VIRGINIA FRIEND				2. DATE OF DEATH MONTH APRIL DAY 19 , YEAR 1995		3. TIME OF DEATH 08:23 A M	
4. SOCIAL SECURITY NUMBER 215-34-4849		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 84 YRS.	7. DATE OF BIRTH (Month, Day, Year) Oct 11, 1910		8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not institution, give street and number) Sacred Heart Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Cumberland		9c. COUNTY OF DEATH Allegany	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Garrett		10c. CITY, TOWN OR LOCATION Friendsville		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 2609 Blooming Rose Road				10f. ZIP CODE 21531		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 th College (1-4 or 5+) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) Herbert Friend				18. MOTHER'S NAME (First, Middle, Maiden Surname) Anna DeWitt			
19a. INFORMANT'S NAME (Type/Print) JoAnn M. Smith				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2609 Blooming Rose Rd., Friendsville, MD 21531			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Blooming Rose Cem. Apr. 23, 95		20c. LOCATION — City or Town, State Friendsville, MD		20d. DATE Apr. 23, 95	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY Newman Funeral Homes, P.A. 155 Main St., Grantsville, MD 21536			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ACUTE RESPIRATORY FAILURE DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { b. PNEUMONIA DUE TO (OR AS A CONSEQUENCE OF):							
c. SUBARACHNOID HEMORRHAGE DUE TO (OR AS A CONSEQUENCE OF):							
d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Other		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> M.D.				29c. LICENSE NUMBER 23334-D		29d. DATE SIGNED (Month, Day, Year) APRIL 19 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DINGSH B. SHAH, MD; 205 JOHNSON'S HEIGHTS MEDICAL BUILDING, Cumberland, MD 21502							
31. DATE FILED (Month, Day, Year) APR 21 1995		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13732

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Walter William Frauman, IV				2. DATE OF DEATH APR 18, 1995		3. TIME OF DEATH 12:15 A.M.	
4. SOCIAL SECURITY NUMBER 266-63-0297		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 33 YRS.		7. DATE OF BIRTH (Month, Day, Year) October 22, 1961	
9a. FACILITY NAME (If not institution, give street and number) 5-H Eastway Road		9b. CITY, TOWN OR LOCATION OF DEATH Greenbelt		9c. COUNTY OF DEATH Prince George's			
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Prince George's		10c. CITY, TOWN OR LOCATION Greenbelt		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 5-H Eastway Road				10f. ZIP CODE 20770		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 7		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Social Security Specialist		16b. KIND OF BUSINESS/INDUSTRY United States Government Social Security Administration			
17. FATHER'S NAME (First, Middle, Last) Walter William Frauman, III				18. MOTHER'S NAME (First, Middle, Maiden Surname) Sally Annette Crosby			
19a. INFORMANT'S NAME (Type/Print) Deanna Lynn Peel (wife)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) same as #10			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metropolitan Crematory April 19, 1995		20c. LOCATION — City or Town, State Alexandria, Virginia			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Donald V. Borgwardt				22. NAME AND ADDRESS OF FACILITY Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Md. 20705			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiopulmonary Arrest DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. Non Hodgkin's Lymphoma DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death Minutes 2 years
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH XX Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Imad Tabbara				29c. LICENSE NUMBER 18948		29d. DATE SIGNED (Month, Day, Year) April 19, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Imad Tabbara, M.D. 2150 Pennsylvania Avenue, N.W. Washington, D.C. 20037							
31. DATE FILED (Month, Day, Year) APR 20 1995				32. REGISTRAR'S SIGNATURE John Davidson Marshall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.


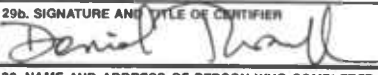
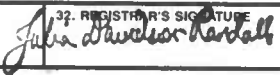
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13733

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) PEGGY C. FITZPATRICK				2. DATE OF DEATH MONTH DAY YEAR APR. 20, 1995		3. TIME OF DEATH 12:30 AM	
4. SOCIAL SECURITY NUMBER 215-54-5792		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (in yrs. last birthday) 66 YRS.		7. DATE OF BIRTH (Month, Day, Year) JAN. 22, 1929	
9a. FACILITY NAME (If not institution, give street and number) 10308 DETRICK AVE				9b. CITY, TOWN OR LOCATION OF DEATH KENSINGTON		9c. COUNTY OF DEATH MONTGOMERY	
10a. STATE MD.		10b. COUNTY MONTGOMERY		10c. CITY, TOWN OR LOCATION KENSINGTON		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 10308 DETRICK AVE.				10f. ZIP CODE 20895		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) HOUSEWIFE		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOUSEWIFE		16b. KIND OF BUSINESS/INDUSTRY AT HOME			
17. FATHER'S NAME (First, Middle, Last) MONROE H. EDWARDS				18. MOTHER'S NAME (First, Middle, Maiden Surname) RUBY MAE SATTERFIELD			
19a. INFORMANT'S NAME (Type/Print) SUSAN C. FITZPATRICK				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) SAME AS ITEM #10			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) CHAMBERS CREMATORY 4/21		20c. LOCATION — City or Town, State RIVERDALE, MD.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY SILVER SPRING, MD. W. W. CHAMBERS CO. INC. 20910					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → BREAST CANCER DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death 3 years
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER  MD				29c. LICENSE NUMBER D04766		29d. DATE SIGNED (Month, Day, Year) 4-20-95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DANIEL ROSENBLUM 10400 CONNECTICUT AVE 606 KENSINGTON, MD 20895							
31. DATE FILED (Month, Day, Year) APR 21 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13734

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) BABY BOY				2. DATE OF DEATH MONTH MARCH DAY 27 YEAR 1995				3. TIME OF DEATH 11:55P M	
4. SOCIAL SECURITY NUMBER		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) YRS. MONTHS DAYS 6		7. DATE OF BIRTH (Month, Day, Year) March 21, 1995		8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY				9c. COUNTY OF DEATH Baltimore	
10a. STATE Maryland		10b. COUNTY Washington		10c. CITY, TOWN OR LOCATION Hagerstown				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 11310 Englewood Road				10f. ZIP CODE 21740		10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) none College (1-4 or 5+) none		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) none		16b. KIND OF BUSINESS/INDUSTRY none					
17. FATHER'S NAME (First, Middle, Last) Rikki Alan Parks, Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Traci Michele Wolford					
19a. INFORMANT'S NAME (Type/Print) Rikki A. Parks, Sr.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11310 Englewood Road Hagerstown, Maryland 21740					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Rest Haven Cemetery		DATE 3/30		20c. LOCATION — City or Town, State Hagerstown, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Gerald N. Minnich</i>				22. NAME AND ADDRESS OF FACILITY Gerald N. Minnich 305 N. Potomac Street Hagerstown, Maryland /					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cardiac Ischemia Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. Cardiac Ischemia DUE TO (OR AS A CONSEQUENCE OF): 10 minutes b. Irregular Respirations DUE TO (OR AS A CONSEQUENCE OF): 20 minutes c. Brainstem Ischemia DUE TO (OR AS A CONSEQUENCE OF): 3 days d. Neonatal Asphyxia DUE TO (OR AS A CONSEQUENCE OF): 6 days								Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>L. Viennas MD</i>				29c. LICENSE NUMBER 1-2069		29d. DATE SIGNED (Month, Day, Year) 3/28/95			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Zaharoula Viennas 600 N. Wolfe St. Baltimore, MD 21287									
31. DATE FILED (Month, Day, Year) MAR 31 1995									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13735

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Mary Eleanor Fellner				2. DATE OF DEATH MONTH DAY YEAR April 20, 1995		3. TIME OF DEATH 6:30 A M	
4. SOCIAL SECURITY NUMBER 577-48-1908		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 83 YRS.		7. DATE OF BIRTH (Month, Day, Year) Jun 14, 1911	
8. BIRTHPLACE (State or Foreign Country) Waynesboro, PA				9a. FACILITY NAME (If not institution, give street and number) Physicians Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH La Plata	
9c. COUNTY OF DEATH Charles				10a. STATE MD		10b. COUNTY Charles	
10c. CITY, TOWN OR LOCATION White Plains				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 10481 Willetts Crossing Road	
10f. ZIP CODE 20695				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Nurse		16b. KIND OF BUSINESS/INDUSTRY Hospital	
17. FATHER'S NAME (First, Middle, Last) Daniel Singer Geiser				18. MOTHER'S NAME (First, Middle, Maiden Surname) Eleanor Brubaker			
19a. INFORMANT'S NAME (Type/Print) Jon S. Fellner				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10481 Willetts Crossing RD, White Plains, MD 20695			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Green Hill Cemetery 4/22		20c. LOCATION — City or Town, State Waynesboro PA 17268	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE James A. Bowersox				22. NAME AND ADDRESS OF FACILITY Grove Funeral Home, Inc. 50 S. Broad ST, Waynesboro, PA 17268			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Respiratory Failure b. Diffuse Pulmonary Fibrosis c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER Michael A. Leatherwood, MD				29c. LICENSE NUMBER D-21031		29d. DATE SIGNED (Month, Day, Year) 4/20/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Michael Leatherwood, MD Waldorf Medical Park P.O. Box 249 Waldorf, Maryland 20604							
31. DATE FILED (Month, Day, Year) APR 21 1995							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13736

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) GEORGE C. FOX				2. DATE OF DEATH MONTH 4 DAY 10 YEAR 95		3. TIME OF DEATH 8:55 PM	
4. SOCIAL SECURITY NUMBER 238-40-4085		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 71 YRS.		7. DATE OF BIRTH (Month, Day, Year) 2-22-1924	
9a. FACILITY NAME (If not Institution, give street and number) Chesapeake Manor Nursing Ctr.				9b. CITY, TOWN OR LOCATION OF DEATH Arnold		9c. COUNTY OF DEATH Anne Arundel	
10a. STATE MD				10b. COUNTY Anne Arundel		10c. CITY, TOWN OR LOCATION Arnold	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 213 Doncaster Rd.			
10f. ZIP CODE 21012				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1943-1976		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 5+ College (1-4 or 5+) 5+				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Marine Corps.		16b. KIND OF BUSINESS/INDUSTRY Military	
17. FATHER'S NAME (First, Middle, Last) Richard Lauman Fox				18. MOTHER'S NAME (First, Middle, Maiden Surname) Jean Christie Bull			
19a. INFORMANT'S NAME (Type/Print) Frances G. Fox				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 213 Doncaster Rd. Arnold MD 21012			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Arlington National Cem		20c. LOCATION — City or Town, State Arlington, Va.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY 495 Ritchie Hwy. Barranco & Sons FH Severna Park MD			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Carcinoma of lung, Metastatic Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate Interval Between Onset and Death 1 yr.	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> Attending Doctor		29c. LICENSE NUMBER D21684		29d. DATE SIGNED (Month, Day, Year) 4/12/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) C.V. CYRIAC-M.D. 1600 CRAIN HWY #106, GLENBURNIE MD 21061.							
31. DATE FILED (Month, Day, Year) APR 21 1995		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

VOID

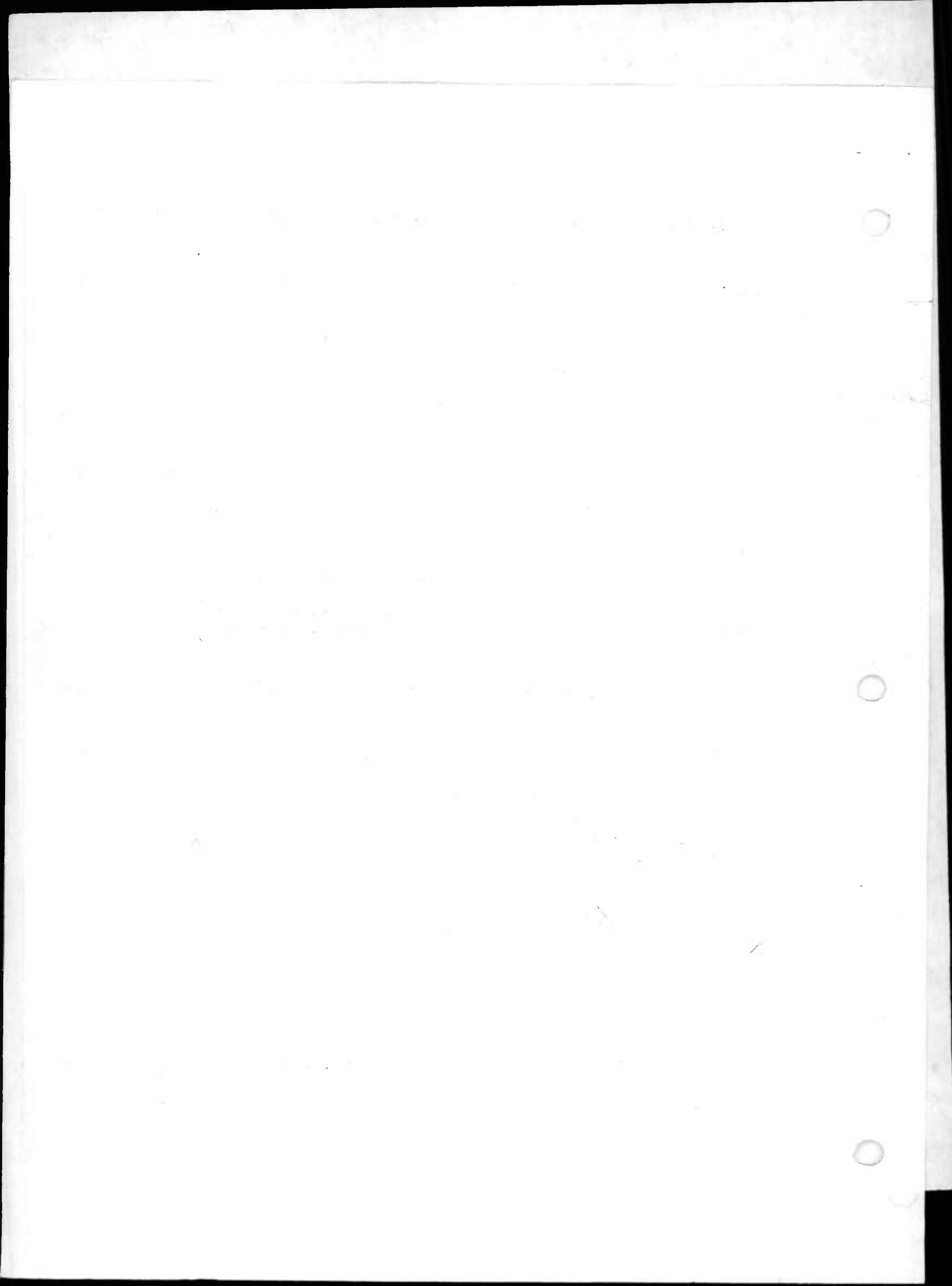
CERTIFICATE 00

95-13737

SEE

CERTIFICATE 00

95-14955



95 13738

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ALFHILD L. FEUSTEL				2. DATE OF DEATH MONTH APRIL DAY 16 , YEAR 1995		3. TIME OF DEATH 2:20 a.m.	
4. SOCIAL SECURITY NUMBER 157-30-8693		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 88 YRS.		7. DATE OF BIRTH (Month, Day, Year) 9/13/1906	
8. BIRTHPLACE (State or Foreign Country) Sweden				9a. FACILITY NAME (If not institution, give street and number) SAINT JOSEPH MEDICAL CENTER		9b. CITY, TOWN OR LOCATION OF DEATH TOWSON, MD	
9c. COUNTY OF DEATH BALTIMORE				10a. STATE MD.			
10b. COUNTY Carroll				10c. CITY, TOWN OR LOCATION Westminster			
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 4626 Old Hanover Rd.			
10f. ZIP CODE 21158				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Lingerie distributor		16b. KIND OF BUSINESS/INDUSTRY factory - lingerie			
17. FATHER'S NAME (First, Middle, Last) John Emil Carlson				18. MOTHER'S NAME (First, Middle, Maiden Surname) Jennie Alexina Lofgrin			
19a. INFORMANT'S NAME (Type/Print) Pam Holmes				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4626 Old Hanover Rd., Westminster, Md. 21158			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Carroll Cremation Inc. 4/17/95		20c. LOCATION — City or Town, State Hampstead, Md.		20d. DATE 4/17/95	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Robert A. Magnus</i>				22. NAME AND ADDRESS OF FACILITY MURKIN FUNERAL HOME 2157 91 WILKIE STREET, WESTMINSTER, MD			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. ACUTE ANTERIOR MYOCARDIAL INFARCTION				Approximate interval Between Onset and Death DAYS	
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. CONGESTIVE HEART FAILURE				DAYS	
		c. VENTRICULAR SEPTAC DEFECT				DAYS	
		d. POLYMYALGIA RHEUMATICA				YEARS	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
AORTIC REGURITATION							
SEIZURE DISORDER							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Ceballos, MD</i>		29c. LICENSE NUMBER D 25886		29d. DATE SIGNED (Month, Day, Year) 4.16.95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR CEBALLOS, 7620 YORK ROAD TOWSON, MARYLAND 21204							
31. DATE FILED (Month, Day, Year) APR 17 1995 <i>Julia</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13739

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Robert Lee Fletcher				2. DATE OF DEATH MONTH 4 DAY 11 YEAR 95		3. TIME OF DEATH 21:55 M	
4. SOCIAL SECURITY NUMBER 231-42-8381		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 59 YRS.		7. DATE OF BIRTH (Month, Day, Year) 4/14/1935	
8. BIRTHPLACE (State or Foreign Country) Virginia				9a. FACILITY NAME (If not institution, give street and number) Carroll County General Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Westminster	
9c. COUNTY OF DEATH Carroll				10a. STATE Virginia		10b. COUNTY n/a	
10c. CITY, TOWN OR LOCATION Chesapeake				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 1218 Lilac Avenue	
10f. ZIP CODE 23325				10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2+ College (1-4 or 5+) 2+		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) field technician		16b. KIND OF BUSINESS/INDUSTRY Westinghouse			
17. FATHER'S NAME (First, Middle, Last) Roy Fletcher				18. MOTHER'S NAME (First, Middle, Maiden Surname) Doris Shay			
19a. INFORMANT'S NAME (Type/Print) Tracey Jackson				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1753 Bloom Rd., Westminster, MD 21157			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Trinity Lutheran Cemetery		20c. LOCATION — City or Town, State Taneytown, MD		20d. DATE OF DISPOSITION 4/15/95	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Katharine Pitts - Switzer				22. NAME AND ADDRESS OF FACILITY Pritts Funeral Home & Chapel 412 Washington Rd., Westminster, MD			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → acute myocardial infarction Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Coronary artery Disease Peripheral vascular disease Complete heart block S/P PDD PACER							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER D. S. Kaloria				29c. LICENSE NUMBER D23015		29d. DATE SIGNED (Month, Day, Year) 4/12/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DINESH S. KALARIA 217 WASHINGTON HTGTS WESTMINSTER, MD 21157							
31. DATE FILED (Month, Day, Year) APR 17 1995		32. REGISTRAR'S SIGNATURE Julia B. K. R. R. R.					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

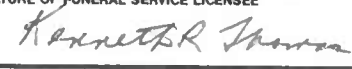


TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) EDGAR SEWELL GORE				2. DATE OF DEATH MONTH DAY YEAR April 13 1995		3. TIME OF DEATH 10:30 p m	
4. SOCIAL SECURITY NUMBER 220-34-9652		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 88 YRS.	7. DATE OF BIRTH (Month, Day, Year) Nov. 6, 1906		8. BIRTHPLACE (State or Foreign Country) U.S.A. (Md.)	
9a. FACILITY NAME (If not institution, give street and number) 4761 Ravenwood Rd.				9b. CITY, TOWN OR LOCATION OF DEATH Salem		9c. COUNTY OF DEATH Dorchester	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Dorchester		10c. CITY, TOWN OR LOCATION Salem		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 4761 Ravenwood Rd.				10f. ZIP CODE 21869		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE—American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) 2				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Director, Planning & Zoning Office, County gov't.		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) John E. Gore				18. MOTHER'S NAME (First, Middle, Maiden Surname) Helen Elizabeth Barnett			
19a. INFORMANT'S NAME (Type/Print) Mrs. Jeanne B. Gore				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4761 Ravenwood Rd., Vienna MD 21869			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) East New Market Cemetery 4/17		20c. LOCATION—City or Town, State E. New Market Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Thomas Funeral Home 700 Locust St. Cambridge MD 21613			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. cerebrovascular disease Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):						Approximate interval Between Onset and Death 3 yrs	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Nomicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28a. PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER 			
29c. LICENSE NUMBER 039749				29d. DATE SIGNED (Month, Day, Year) 4/14/95			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) David G. Oliver MD 503 Dutchmans Lane Easton MD 21601							
31. DATE FILED (Month, Day, Year) APR 14 1995		32. REGISTRAR'S SIGNATURE 					

95 13741

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) SAMUEL GORDON				2. DATE OF DEATH MONTH DAY YEAR APRIL 16, 1995				3. TIME OF DEATH HOURS MINUTES AM/PM 8:25 A M	
4. SOCIAL SECURITY NUMBER 578-22-7953		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 77 YRS.		7. DATE OF BIRTH (Month, Day, Year) NOV. 5, 1917		8. BIRTHPLACE (State or Foreign Country) WASH., DC	
9a. FACILITY NAME (If not institution, give street and number) SHARON NURSING HOME				9b. CITY, TOWN OR LOCATION OF DEATH OLNEY				9c. COUNTY OF DEATH MONTGOMERY	
RESIDENCE OF DECEDENT									
10a. STATE MARYLAND		10b. COUNTY MONTGOMERY		10c. CITY, TOWN OR LOCATION SILVER SPRING				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 15301 PINE ORCHARD DRIVE #3H				10f. ZIP CODE 20906		10g. CITIZEN OF WHAT COUNTRY? UNITED STATES			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE YEAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 5+ College (1-4 or 5+) 5+				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) ATTORNEY/ JUDGE				16b. KIND OF BUSINESS/INDUSTRY LEGAL	
17. FATHER'S NAME (First, Middle, Last) ISADORE GORDON				18. MOTHER'S NAME (First, Middle, Maiden Surname) LILLIAN PISNER					
19a. INFORMANT'S NAME (Type/Print) NITA GORDON (WIFE)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15301 PINE ORCHARD DR. #3H SILVER SPRING, MD 20906					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) KING DAVID		20c. LOCATION — City or Town, State 4-17 FALLS CHURCH, VIRGINIA			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Frank J. Stone</i>				22. NAME AND ADDRESS OF FACILITY DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. MYOCARDIAL INFARCTION									
DUE TO (OR AS A CONSEQUENCE OF):									
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST									
b. DUE TO (OR AS A CONSEQUENCE OF):									
c. DUE TO (OR AS A CONSEQUENCE OF):									
d.									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. NON-INSULIN DEPENDENT DIABETES MELLITUS POST-TRAUMATIC DEMENTIA									
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
				28d. DESCRIBE HOW INJURY OCCURRED					
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)					
				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Staff Physician</i> STAFF PHYSICIAN				29c. LICENSE NUMBER D42046		29d. DATE SIGNED (Month, Day, Year) April 16, 1995			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) G. BROOKE HUFFMAN, MD 18100 Slade School Rd. Sandy Spring MD 20860									
31. DATE FILED (Month, Day, Year) APR 18 1995				32. REGISTRAR'S SIGNATURE <i>John A. ...</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13742

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Helen W Glazer</i>				2. DATE OF DEATH MONTH: <i>April</i> DAY: <i>14</i> YEAR: <i>1995</i>				3. TIME OF DEATH <i>6:38 P.M.</i>			
4. SOCIAL SECURITY NUMBER <i>097-18-8152</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (in yrs. last birthday) <i>71</i> YRS.	IF UNDER 1 YEAR MONTHS: _____ DAYS: _____		IF UNDER 24 HRS. HOURS: _____ MIN: _____		7. DATE OF BIRTH (Month, Day, Year) <i>NOV. 4, 1923</i>			
8. BIRTHPLACE (State or Foreign Country) <i>NEW YORK</i>				9. FACILITY NAME (If not institution, give street and number) <i>SUBURBAN HOSPITAL</i>				10. CITY, TOWN OR LOCATION OF DEATH <i>BETHESDA</i>			
11. COUNTY OF DEATH <i>MONTGOMERY</i>				12. STATE <i>MARYLAND</i>				13. COUNTY OF DEATH <i>MONTGOMERY</i>			
14. STREET AND NUMBER <i>5225 POOKS HILL ROAD 1812 S.</i>				15. ZIP CODE <i>20814</i>				16. CITIZEN OF WHAT COUNTRY? <i>UNITED STATES</i>			
17. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced				18. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				19. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			
20. RACE — American Indian, Black, White, etc. Specify: <i>WHITE</i>				21. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) _____ College (1-4 or 5+) <i>4</i>				22. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>HOMEMAKER</i>			
23. KIND OF BUSINESS/INDUSTRY <i>OWN HOME</i>				24. FATHER'S NAME (First, Middle, Last) <i>MORRIS KLIGMAN</i>				25. MOTHER'S NAME (First, Middle, Maiden Surname) <i>BERTHA COHEN</i>			
26. INFORMANT'S NAME (Type/Print) <i>HERMAN GLAZER</i>				27. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>5225 POOKS HILL ROAD 1812 S. -BETHESDA, MD. 20814</i>							
28. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				29. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>KING DAVID MEMORIAL GARDEN 4/17</i>				30. LOCATION — City or Town, State <i>FALLS CHURCH, VIRGINIA</i>			
31. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Frank A. Stone</i>				32. NAME AND ADDRESS OF FACILITY <i>DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE-ROCKVILLE, MD. 20852</i>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>SEPTIC SHOCK</i>											
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST											
b. <i>BACTERIAL ENDOCARDITIS</i>											
c. <i>CHEMOTHERAPY</i>											
d. <i>OVARIAN CARCINOMA</i>											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Rheumatic heart disease. Mitral valve replacement</i>											
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO											
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO											
26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide											
28a. DATE OF INJURY (Month, Day, Year)											
28b. TIME OF INJURY <i>M</i>											
28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO											
28d. DESCRIBE HOW INJURY OCCURRED											
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)											
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)											
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Mark T. Birns</i>											
29c. LICENSE NUMBER <i>D24994</i>											
29d. DATE SIGNED (Month, Day, Year) <i>4/14/95</i>											
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>MARK T. BIRNS, MD 9711 MEDICAL GR DR ROCKVILLE, MD</i>											
31. DATE FILED (Month, Day, Year) <i>APR 18 1995</i>											
32. REGISTRAR'S SIGNATURE <i>Julia Davidson Randall</i>											

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13743

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Grace Virginia Grylik</u>				2. DATE OF DEATH MONTH <u>April</u> DAY <u>12</u> YEAR <u>1995</u>				3. TIME OF DEATH <u>0345 AM</u>			
4. SOCIAL SECURITY NUMBER <u>578-26-7840</u>				5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>77</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>Dec 24, 1917</u>		8. BIRTHPLACE (State or Foreign Country) <u>Maryland</u>	
9a. FACILITY NAME (If not institution, give street and number) <u>Shady Grove Adventist Hospital</u>						9b. CITY, TOWN OR LOCATION OF DEATH <u>Rockville</u>			9c. COUNTY OF DEATH <u>Montgomery</u>		
10a. STATE <u>Maryland</u>				10b. COUNTY <u>Montgomery</u>		10c. CITY, TOWN OR LOCATION <u>Rockville</u>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <u>95 Dawson Avenue</u>						10f. ZIP CODE <u>20850</u>		10g. CITIZEN OF WHAT COUNTRY? <u>United States</u>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <u>White</u>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>10</u> College (1-4 or 5+) <u>Housewife</u>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Housewife</u>				16b. KIND OF BUSINESS/INDUSTRY <u>Own Home</u>			
17. FATHER'S NAME (First, Middle, Last) <u>Henry Hilderbrand</u>						18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Virgie Bell Lugenbell</u>					
19a. INFORMANT'S NAME (Type/Print) <u>Frank Thomas Anderson (Son)</u>						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>1805 McGuire Court, Vienna, VA 22182</u>					
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Chesapeake Crematory</u>				DATE <u>4-15</u>		20c. LOCATION — City or Town, State <u>Beltsville, MD</u>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>[Signature]</u> <u>M00827</u>				22. NAME AND ADDRESS OF FACILITY <u>Rapp Funeral Services, P.A.</u> <u>933 Gist Ave, Silver Spring, MD 20910</u>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>a. RESPIRATORY FAILURE</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>RECURRENT BILATERAL ASPIRATION PNEUMONIA</u> DUE TO (OR AS A CONSEQUENCE OF): c. <u>CEREBROVASCULAR ACCIDENT.</u> DUE TO (OR AS A CONSEQUENCE OF): d. Approximate interval between Onset and Death <u>16 DAYS</u> <u>1 MONTH</u>											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</u> <u>CONGESTIVE HEART FAILURE, HYPERTENSION</u> <u>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/></u>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <u>M</u>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <u>[Signature]</u> M.D.						29c. LICENSE NUMBER <u>043358</u>		29d. DATE SIGNED (Month, Day, Year) <u>APRIL 12, 1995</u>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>19506 DOCTORS DRIVE, GERMANTOWN, MARYLAND 20874</u>											
31. DATE FILED (Month, Day, Year) <u>APR 18 1995</u>				32. REGISTRAR'S SIGNATURE <u>[Signature]</u>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13744

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) TIFFANY GODBOLT				2. DATE OF DEATH April 2, 1995		3. TIME OF DEATH 4:20 A	
4. SOCIAL SECURITY NUMBER N/A		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) YRS. MONTHS DAYS		7. DATE OF BIRTH (Month, Day, Year) April 2, 1995	
8a. FACILITY NAME (If not institution, give street and number) Holy Cross Hospital				8b. CITY, TOWN OR LOCATION OF DEATH Silver Spring		8c. COUNTY OF DEATH Montgomery	
RESIDENCE OF DECEDENT							
10a. STATE D.C.		10b. COUNTY		10c. CITY, TOWN OR LOCATION Washington		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 501 60th St. N.E. #301				10f. ZIP CODE 20019		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) N/A		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) N/A		16b. KIND OF BUSINESS/INDUSTRY N/A			
17. FATHER'S NAME (First, Middle, Last) Thomas Jenkins				18. MOTHER'S NAME (First, Middle, Maiden Surname) Tonya Godbolt			
19a. INFORMANT'S NAME (Type/Print) Tonya Godbolt				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 501 60th St. N.E. #301, Wash, DC. 20019			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Harmony Memorial Park 4/10/95		20c. LOCATION — City or Town, State Landover, MD.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 7 d Austin 846				22. NAME AND ADDRESS OF FACILITY Austin Royster Funeral Home 3605 14th St. N.W. Wash. DC. 20010			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		Previabie female (22 weeks gestation)					Approximate Interval Between Onset and Death 2 hor
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		a. DUE TO (OR AS A CONSEQUENCE OF): Preruature labor and prom					2 days
		b. DUE TO (OR AS A CONSEQUENCE OF):					
		c. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Sharon C Kerian MD				29c. LICENSE NUMBER D-19142		29d. DATE SIGNED (Month, Day, Year) April 2, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Sharon C. Kerian, MD, 1500 Forest Glen Rd, Silver Spring, MD.							
31. DATE FILED (Month, Day, Year) APR 17 1995				32. REGISTRAR'S SIGNATURE John Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13745

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) THARLE B. GUYNN				2. DATE OF DEATH MONTH APRIL DAY 18 YEAR 1995		3. TIME OF DEATH 1:43 P.M.	
4. SOCIAL SECURITY NUMBER 578-40-5481		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 64 YRS.		7. DATE OF BIRTH (Month, Day, Year) April 9, 1931	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) Washington Adventist Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Takoma Park	
9c. COUNTY OF DEATH Montgomery				10a. STATE Maryland		10b. COUNTY Prince George's	
10c. CITY, TOWN OR LOCATION Beltsville				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 11709 Roby Avenue	
10f. ZIP CODE 20705				10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 1		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Receptionist		16b. KIND OF BUSINESS/INDUSTRY University of Maryland Univ. Coll.			
17. FATHER'S NAME (First, Middle, Last) Charles F. Stinchcomb				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Donaldson			
19a. INFORMANT'S NAME (Type/Print) Albert J. Guynn, Sr.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) same as #10			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) George Washington Cemetery April 21, 1995		20c. LOCATION — City or Town, State Adelphi, Maryland		20d. DATE April 21, 1995	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Donald V. Borgwardt</i>				22. NAME AND ADDRESS OF FACILITY Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Md. 20705			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Septic shock Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Due to (or as a consequence of): bacterial pneumonia ruptured gall bladder						Approximate Interval Between Onset and Death 2 hrs 4 hrs 4 hrs 6 hrs	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. preexisting chronic disease, multiple myeloma						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURRED					
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		28g. DATE SIGNED (Month, Day, Year) Apr. 18, 1995					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>DR. LEWIS DENNIS</i>		29c. LICENSE NUMBER DD01499		29d. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. LEWIS DENNIS 6201 Greenbelt Rd., U-1 College Park, Md. 20740	
31. DATE FILED (Month, Day, Year) APR 20 1995		32. REGISTRAR'S SIGNATURE <i>Julia Swisher Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13746

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>LILLIAN A GRAVELY</i>				2. DATE OF DEATH MONTH <i>APRIL</i> DAY <i>16</i> YEAR <i>95</i>		3. TIME OF DEATH <i>1:50 P.M.</i>	
4. SOCIAL SECURITY NUMBER <i>578-26-4277</i>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>88</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>May 11, 1906</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Laurel Regional Hospital</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Laurel</i>		9c. COUNTY OF DEATH <i>Prince George's</i>	
RESIDENCE OF DECEDENT							
10a. STATE <i>Maryland</i>		10b. COUNTY <i>Prince George's</i>		10c. CITY, TOWN OR LOCATION <i>Beltsville</i>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <i>11216 Cherry Hill Road</i>				10f. ZIP CODE <i>20705</i>		10g. CITIZEN OF WHAT COUNTRY? <i>United States</i>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yrs. or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i></i>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Receptionist</i>		16b. KIND OF BUSINESS/INDUSTRY <i>C&P Telephone Company</i>	
17. FATHER'S NAME (First, Middle, Last) <i>William A. Duvall</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Vergie M. Hughes</i>			
19a. INFORMANT'S NAME (Type/Print) <i>John F. Gravely</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>4913 Muskogee College Park, Maryland 20740</i>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>George Washington Cemetery April 20, 1995</i>		20c. LOCATION — City or Town, State <i>Adelphi, Maryland</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Donald V. Borgwardt</i>				22. NAME AND ADDRESS OF FACILITY <i>Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Md. 20705</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Congestive heart failure</i>							
DUE TO (OR AS A CONSEQUENCE OF):							
<i>Atrial Fibrillation</i>							
DUE TO (OR AS A CONSEQUENCE OF):							
<i>Chronic Renal Failure</i>							
<i>Anaemia</i>							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>P. S. Anula</i>				29c. LICENSE NUMBER <i>042580</i>		29d. DATE SIGNED (Month, Day, Year) <i>4-17-95</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>P. S. Anula 6501 Landover Rd Choverly MD 20785</i>							
31. DATE FILED (Month, Day, Year) <i>APR 20 1995</i>				32. REGISTRAR'S SIGNATURE <i>Julia D. Marshall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

4

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13747

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) DENNIS JOSEPH GRETZ				2. DATE OF DEATH MONTH DAY YEAR APR 18 1995		3. TIME OF DEATH 5:30 P M	
4. SOCIAL SECURITY NUMBER 187-32-2671		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 53 YRS.		7. DATE OF BIRTH (Month, Day, Year) Oct 6, 1941	
9a. FACILITY NAME (If not institution, give street and number) NATIONAL NAVAL MEDICAL CENTER				9b. CITY, TOWN OR LOCATION OF DEATH BETHESDA		9c. COUNTY OF DEATH MONTGOMERY	
10a. STATE Maryland				10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Wheaton	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 11613 College View Drive			
10f. ZIP CODE 20902				10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES U.S.M.C.		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Manager		16b. KIND OF BUSINESS/INDUSTRY C & P Telephone			
17. FATHER'S NAME (First, Middle, Last) Frank Ferdinand Gretz				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Cimpinski			
19a. INFORMANT'S NAME (Type/Print) Marcia Gretz (Wife)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as #10			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) U.S.U.H.S.		DATE 4-19		20c. LOCATION — City or Town, State Bethesda, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE M00827				22. NAME AND ADDRESS OF FACILITY Rapp Funeral Services, P.A. 933 Gist Ave, Silver Spring, MD 20910			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. METASTATIC LUNG CANCER DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate interval Between Onset and Death 4 years
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER 0101050362 (VA)		29d. DATE SIGNED (Month, Day, Year) 19 APR 95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) M. ZUHDI JASSER, LT. MC, USNR				NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600			
31. DATE FILED (Month, Day, Year) APR 21 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

REG. NO.

DHMH-16 Rev 1/89

1. The first part of the report

is a description of the

method used in the study

and the results of the

study are given in the

second part of the report

and the third part of the

report is a discussion of

the results of the study

and the conclusions of the

study are given in the

fourth part of the report

and the fifth part of the

report is a summary of the

study and the conclusions of

the study are given in the

sixth part of the report

and the seventh part of the

report is a list of the

references used in the study

and the eighth part of the

report is a list of the

figures used in the study

and the ninth part of the

report is a list of the

tables used in the study

and the tenth part of the

report is a list of the

figures used in the study

and the eleventh part of the

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tables used in the study

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report is a list of the

figures used in the study

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seventeenth part of the

95 13749

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JAMES ALLEN GARBER				2. DATE OF DEATH MONTH 04 DAY 13 YEAR 95		3. TIME OF DEATH 7 A M	
4. SOCIAL SECURITY NUMBER 219-16-0574		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 82 YRS.		7. DATE OF BIRTH (Month, Day, Year) Nov 5, 1912	
8a. FACILITY NAME (If not institution, give street and number) 3 W. BROADWAY		8b. CITY, TOWN OR LOCATION OF DEATH UNION BRIDGE		8c. COUNTY OF DEATH CARROLL			
10a. STATE MD		10b. COUNTY CARROLL		10c. CITY, TOWN OR LOCATION UNION BRIDGE		10d. INSIDE CITY LIMITS <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 3 W. BROADWAY		10f. ZIP CODE 21791		10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES NO		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify NO		14. RACE — American Indian, Black, White, etc. Specify WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (14 or 5+) NO		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CARPENTER		16b. KIND OF BUSINESS/INDUSTRY CONSTRUCTION			
17. FATHER'S NAME (First, Middle, Last) EDWARD THOMAS GARBER				18. MOTHER'S NAME (First, Middle, Maiden Surname) LENI GRAY REPP			
19a. INFORMANT'S NAME (Type/Print) HELEN P. GARBER				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 W. BROADWAY UNION BRIDGE MD 21791			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) PIPE CREEK CEMETERY		20c. LOCATION — City or Town, State NR. NEW WINDSOR, MD		20d. DATE 4/15	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Catharine D. Hartzler</i>				22. NAME AND ADDRESS OF FACILITY D. D. HARTZLER & SONS UNION BRIDGE, MD			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Coronary heart disease DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Congestive heart failure Acute bronchitis							Approximate Interval Between Onset and Death 20+ yrs
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Congestive heart failure Acute bronchitis							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>J. H. Caricore MD</i>				29c. LICENSE NUMBER D 906		29d. DATE SIGNED (Month, Day, Year) 4/13/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J. H. CARICORE MD. P.O. Box 1110 Union Bridge Md 21791							
31. DATE FILED (Month, Day, Year) APR 17 1995				32. REGISTRAR'S SIGNATURE <i>John A. Carroll</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

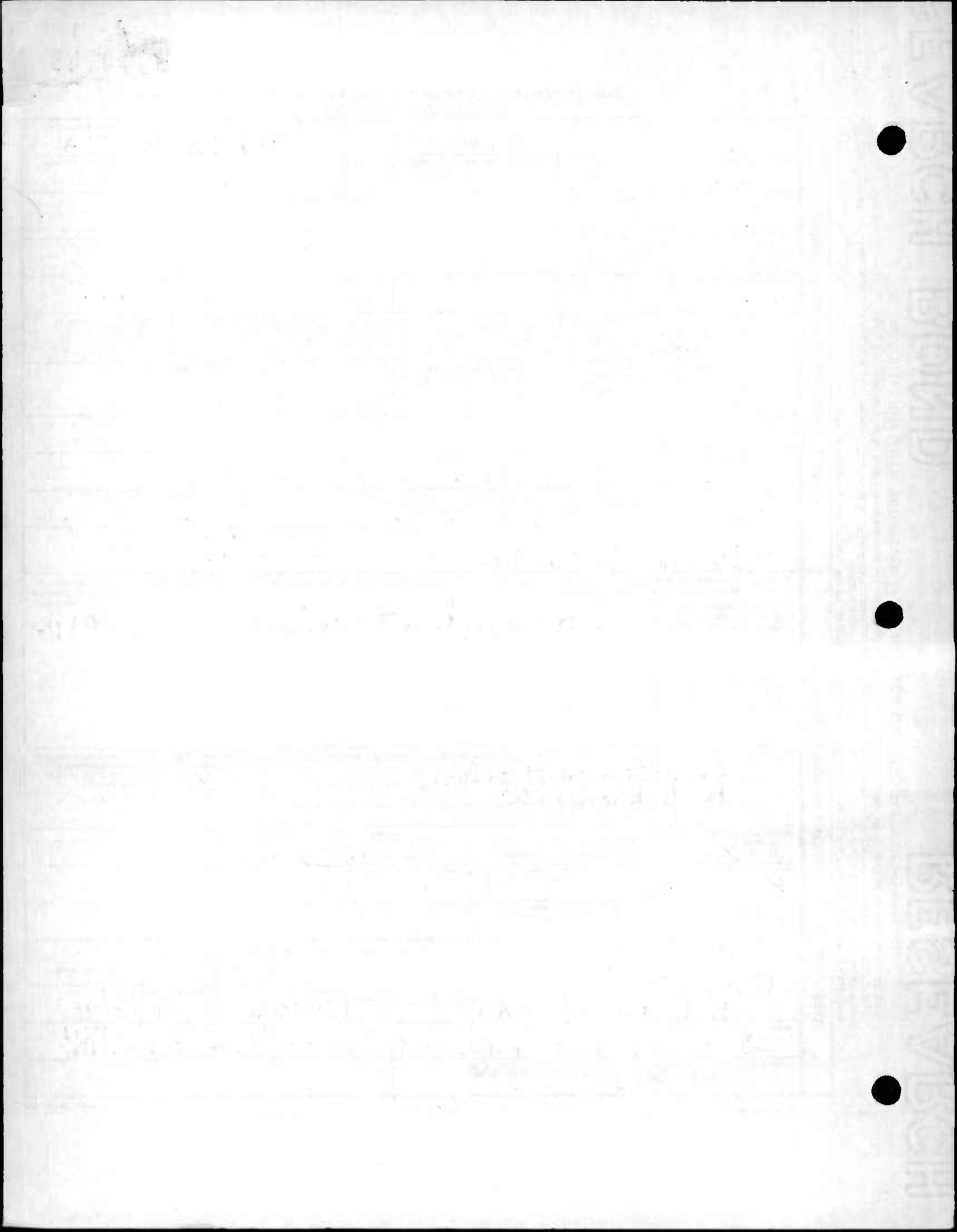
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 13750

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) VIRGINIA E. HUFFMAN				2. DATE OF DEATH MONTH April DAY 10 , YEAR 1995		3. TIME OF DEATH 7:40 a m	
4. SOCIAL SECURITY NUMBER 219-76-1308		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 81 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) FEB 18 1914	
8. BIRTHPLACE (State or Foreign Country) W.VA.							
9a. FACILITY NAME (If not institution, give street and number) MEMORIAL HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH CUMBERLAND		9c. COUNTY OF DEATH ALLEGANY	
10a. STATE MARYLAND				10b. COUNTY ALLEGANY		10c. CITY, TOWN OR LOCATION CUMBERLAND	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
10e. STREET AND NUMBER 815 OLD TOWN ROAD				10f. ZIP CODE 21502		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOUSE KEEPER		16b. KIND OF BUSINESS/INDUSTRY HOUSE KEEPER			
17. FATHER'S NAME (First, Middle, Last) SAMUEL S. SUNDERLIN				18. MOTHER'S NAME (First, Middle, Maiden Surname) BERTHA WARD			
19a. INFORMANT'S NAME (Type/Print) MARION WILLIAM HUFFMAN				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 815 OLD TOWN ROAD CUMBERLAND MARYLAND 21502			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) FOREST GLEN CEMETERY APRIL 12 1995 GREENSPRING W.VA.		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Dale L. Merritt</i>				22. NAME AND ADDRESS OF FACILITY MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Coronary Artery Disease</i> a. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death <i>75 years</i>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Diabetes Mellitus</i>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Terry Williams</i>				29c. LICENSE NUMBER D 16041		29d. DATE SIGNED (Month, Day, Year) April 11, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Terry Williams-Memorial Hospital Medical Building-Cumberland, MD 21502							
31. DATE FILED (Month, Day, Year) APR 12 1995		32. REGISTRAR'S SIGNATURE <i>J. A. ...</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) VERNON V. HUMBERSON				2. DATE OF DEATH MONTH DAY YEAR APRIL 14 95		3. TIME OF DEATH 8:02A M				
4. SOCIAL SECURITY NUMBER 215-20-5598		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 71 YRS.		7. DATE OF BIRTH (Month, Day, Year) Mar 19, 1924		8. BIRTHPLACE (State or Foreign Country) Pennsylvania		
9a. FACILITY NAME (If not institution, give street and number) 1637 Old Morgantown Rd., West, route 1 Box 25				9b. CITY, TOWN OR LOCATION OF DEATH FRIENDSVILLE			9c. COUNTY OF DEATH GARRETT			
10a. STATE Maryland		10b. COUNTY Garrett		10c. CITY, TOWN OR LOCATION Friendsville			10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 1637 Old Morgantown Rd., West				10f. ZIP CODE 21531		10g. CITIZEN OF WHAT COUNTRY? USA				
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW 2		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 th		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Disabled Veteran		16b. KIND OF BUSINESS/INDUSTRY Disabled						
17. FATHER'S NAME (First, Middle, Last) Fred Humberson				18. MOTHER'S NAME (First, Middle, Maiden Surname) LaWanda Knapp						
19a. INFORMANT'S NAME (Type/Print) Bruce F. Humberson				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 526 Bear Creek Rd., Friendsville, MD 21531						
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Humberson Cemetery Apr. 18, 95		DATE		20c. LOCATION — City or Town, State Friendsville, MD				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE D. Lynn Newman				22. NAME AND ADDRESS OF FACILITY Newman Funeral Homes, P.A. 155 Main St., Grantsville, MD 21536						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CONTACT GUNSHOT WOUND OF HEAD DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death SUDDEN			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? XX YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 4 14 95		28b. TIME OF INJURY UNE M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED SUDDEN SHOT SELF		
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) RESIDENCE				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) Route 1, Box 25, Garrett County						
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. XX MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. SIGNATURE AND TITLE OF CERTIFIER Monte Frey				29c. LICENSE NUMBER O.C.M.E			29d. DATE SIGNED (Month, Day, Year) APRIL 15/95			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARYDAN A. KOREN 111 PENN STREET, BALTIMORE, MARYLAND 21201										
31. DATE FILED (Month, Day, Year) APR 21 1995				32. REGISTRAR'S SIGNATURE John Drueker-Randall						

+ IVA

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

95 13752

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ERMA Mearl HOPKINS				2. DATE OF DEATH MONTH 4 DAY 10 YEAR 95		3. TIME OF DEATH 3:00 A M	
4. SOCIAL SECURITY NUMBER UNKNOWN		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 79 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) June 1, 1915	
8. BIRTHPLACE (State or Foreign Country) West Virginia				9a. FACILITY NAME (If not institution, give street and number) Bon Secours Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore	
9c. COUNTY OF DEATH Baltimore				10a. STATE MD		10b. COUNTY Baltimore	
10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 222 Furrow Street	
10f. ZIP CODE 21223				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Seamstress		16b. KIND OF BUSINESS/INDUSTRY Emblem Manufacture	
17. FATHER'S NAME (First, Middle, Last) Harry Griffith				18. MOTHER'S NAME (First, Middle, Maiden Surname) Lucy Taylor			
19a. INFORMANT'S NAME (Type/Print) Esther D. Bray				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 222 Furrow St., Baltimore, MD 21223			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Davis Cemetery		20c. LOCATION — City or Town, State 6/13 Davis, West Virginia	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Bradley A. Stewart				22. NAME AND ADDRESS OF FACILITY 32 S. Second St. 21550 STEWART F.H. Oakland, MD			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Metastatic small cell lung cancer DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. 							Approximate interval Between Onset and Death Months
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Elias Abboud, M.D.				29c. LICENSE NUMBER 043235		29d. DATE SIGNED (Month, Day, Year) 4/10/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Elias Abboud M.D. Bon Secours Hospital.							
31. DATE FILED (Month, Day, Year) APR 19 1995				32. REGISTRAR'S SIGNATURE John Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

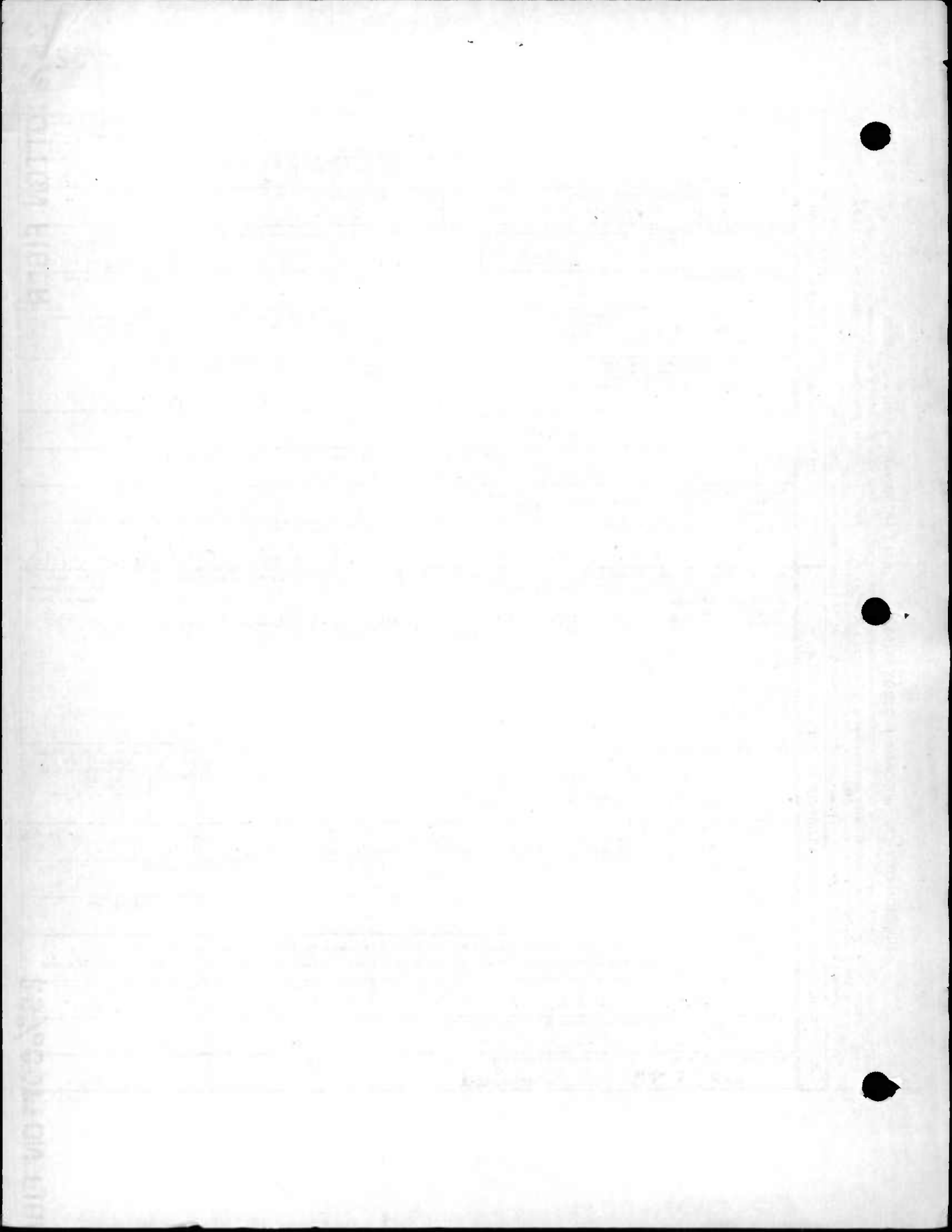
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 13753

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) BABY BOY HAYES				2. DATE OF DEATH MONTH APRIL DAY 14 YEAR 1995		3. TIME OF DEATH 9:30 A.	
4. SOCIAL SECURITY NUMBER		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) YRS.		7. DATE OF BIRTH (Month, Day, Year) April 14, 1995	
9a. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY		9c. COUNTY OF DEATH	
RESIDENCE OF DECEASED							
10a. STATE Maryland		10b. COUNTY		10c. CITY, TOWN OR LOCATION		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER				10f. ZIP CODE		10g. CITIZEN OF WHAT COUNTRY?	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Maiden Surname) Theresa A. Hayes			
19a. INFORMANT'S NAME (Type/Print) Theresa A. Hayes				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8910 Danton Avenue, North Beach, Maryland 20714			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) The Johns Hopkins Hospital		20c. LOCATION — City or Town, State 4/14/95 Baltimore, Maryland		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE The Johns Hopkins Hospital				22. NAME AND ADDRESS OF FACILITY 600 North Wolfe Street, Baltimore, Maryland			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Extreme Prematurity DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. maternal placenta abruption							
24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Maria A. Paine MD (Neonatal Physician)				29c. LICENSE NUMBER M1960		29d. DATE SIGNED (Month, Day, Year) 4/14/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Johns Hopkins Hospital Baltimore, Maryland							
31. DATE MAY 03 1995		32. REGISTRAR'S SIGNATURE John A. Harrison					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) JOHN HREBIK				2. DATE OF DEATH MONTH April DAY 14 YEAR 1995				3. TIME OF DEATH 3:10 P M		
4. SOCIAL SECURITY NUMBER 196-18-0554-0544		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 69 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS. HOURS 0 MIN. 0		
7. DATE OF BIRTH (Month, Day, Year) June 23, 1925				8. BIRTHPLACE (State or Foreign Country) Pennsylvania						
9a. FACILITY NAME (If not institution, give street and number) 4004 Lakeview Turn				9b. CITY, TOWN OR LOCATION OF DEATH Dunkirk				9c. COUNTY OF DEATH Calvert		
RESIDENCE OF DECEDENT										
10a. STATE Maryland		10b. COUNTY Calvert		10c. CITY, TOWN OR LOCATION Dunkirk				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
10e. STREET AND NUMBER 4004 Lakeview Turn				10f. ZIP CODE 20754		10g. CITIZEN OF WHAT COUNTRY? United States				
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Aircraft Inspector				16b. KIND OF BUSINESS/INDUSTRY TWA Airlines		
17. FATHER'S NAME (First, Middle, Last) Steve Hrebik				18. MOTHER'S NAME (First, Middle, Maiden Surname) Helen Petrilla						
19a. INFORMANT'S NAME (Type/Print) Catherine Leason (Sister)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12605 Trumble Drive, Upper Marlboro, MD 20735						
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) St. Peter and Paul Cemetery 4-18		20c. LOCATION — City or Town, State Windber, PA				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE MO0827				22. NAME AND ADDRESS OF FACILITY Rapp Funeral Services, P.A. 933 Gist Ave, Silver Spring, MD 20910						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → PANCREATIC CANCER DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.									Approximate interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>										
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. SIGNATURE AND TITLE OF CERTIFIER JONATHAN D. LOWENTHAL MD				29c. LICENSE NUMBER D33123		29d. DATE SIGNED (Month, Day, Year) 4-14-95				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JONATHAN D. LOWENTHAL MD; 120 HOSPITAL ROAD; PRINCE FREDERICK, MD 20678										
31. DATE FILED (Month, Day, Year) APR 18 1995				32. REGISTRAR'S SIGNATURE John A. Davidson						

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13755

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ROSA MAE HINES				2. DATE OF DEATH MONTH APRIL DAY 13 YEAR 1995		3. TIME OF DEATH 6:05 P.M.	
4. SOCIAL SECURITY NUMBER 241-30-1584		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 88 YRS.		7. DATE OF BIRTH (Month, Day, Year) Apr. 16, 1906	
9a. FACILITY NAME (If not institution, give street and number) Holy Cross Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring		9c. COUNTY OF DEATH MONTGOMERY	
10a. STATE Maryland				10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Silver Spring	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 13207 Dauphine Street		10f. ZIP CODE 20906	
10g. CITIZEN OF WHAT COUNTRY? U.S.A.				11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: Black		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7th College (1-4 or 5+) 	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife				16b. KIND OF BUSINESS/INDUSTRY None		17. FATHER'S NAME (First, Middle, Last) Golett Hood	
18. MOTHER'S NAME (First, Middle, Maiden Surname) Betty Elliott				19a. INFORMANT'S NAME (Type/Print) Marjorie Goggins (Daughter)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13207 Dauphine Street, Silver Spring, MD 20906	
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Parklawn Mem. Park 4/22		20c. LOCATION — City or Town, State Rockville, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>George R. Snowden</i>				22. NAME AND ADDRESS OF FACILITY SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Ruptured thoracic aneurysm DUE TO (OR AS A CONSEQUENCE OF): Approximate interval Between Onset and Death 2 wks Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ARDS							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. DESCRIBE HOW INJURY OCCURRED			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Jeannie P. Asher MD</i>				29c. LICENSE NUMBER 034032		29d. DATE SIGNED (Month, Day, Year) 4/14/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JEANNIE P. ASHER MD 3720 FARRAGUT AVE KENSINGTON MD 20895							
31. DATE FILED (Month, Day, Year) APR 18 1995				32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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95 13756

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) HILDA O. Hocevar				2. DATE OF DEATH MONTH APRIL DAY 11 YEAR 1995				3. TIME OF DEATH 1311 M		
4. SOCIAL SECURITY NUMBER 223-42-5485		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 68 YRS.	IF UNDER 1 YEAR MONTHS XX DAYS XX		IF UNDER 24 HRS. HOURS XX MIN. XX		7. DATE OF BIRTH (Month, Day, Year) May 22, 1926		
9a. FACILITY NAME (If not institution, give street and number) Shady Grove Adventist Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Rockville				9c. COUNTY OF DEATH Montgomery		
10a. STATE Maryland			10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Silver Spring			10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
10e. STREET AND NUMBER 3310 N. Leisure World Blvd., #904				10f. ZIP CODE 20906		10g. CITIZEN OF WHAT COUNTRY? United States				
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker			16b. KIND OF BUSINESS/INDUSTRY Own Home				
17. FATHER'S NAME (First, Middle, Last) Joseph Schuster				18. MOTHER'S NAME (First, Middle, Maiden Surname) Magdalena Wetzstein						
19a. INFORMANT'S NAME (Type/Print) Richard G. Hocevar				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3310 N. Leisure World Blvd. #904, Silver Spring, Md. 20906						
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metropolitan Crematory 4/12/95			DATE 4/12/95		20c. LOCATION — City or Town, State Alexandria, Virginia			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Muriel H. Barber				22. NAME AND ADDRESS OF FACILITY Muriel H. Barber Funeral Home 20882 P. O. Box 5038, Laytonsville, Maryland						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → INTERSTITIAL LUNG FIBROSIS DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate interval between Onset and Death 4 months		
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. OVARIAN CANCER								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. SIGNATURE AND TITLE OF CERTIFIER Carl I. Schoenberger MD				29c. LICENSE NUMBER D 26540		29d. DATE SIGNED (Month, Day, Year) APRIL 11 1995				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Carl I. Schoenberger 16220 Frederick Rd. Gaithersburg, Md.										
31. DATE FILED (Month, Day, Year) APR 17 1995		32. REGISTRAR'S SIGNATURE John Davidson Randall								

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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95 13757

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ANTHONY RUSSELL HNAT				2. DATE OF DEATH MONTH DAY YEAR APRIL 11 1995		3. TIME OF DEATH 4:52 P M	
4. SOCIAL SECURITY NUMBER 551-80-5957		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 44 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) DECEMBER 4 1950	
9a. FACILITY NAME (If not institution, give street and number) NATIONAL NAVAL MEDICAL CENTER				9b. CITY, TOWN OR LOCATION OF DEATH BETHESDA		9c. COUNTY OF DEATH MONTGOMERY	
10a. STATE VIRGINIA		10b. COUNTY FAIRFAX		10c. CITY, TOWN OR LOCATION FAIRFAX		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 5408 CHATSWORTH COURT				10f. ZIP CODE 22032		10g. CITIZEN OF WHAT COUNTRY? UNITED STATES	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES DEC. 18, 1986 - AUG. 31, 1994		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: CAUCASIAN	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) OFFICER		16b. KIND OF BUSINESS/INDUSTRY UNITED STATES AIR FORCE			
17. FATHER'S NAME (First, Middle, Last) JOHN HNAT				18. MOTHER'S NAME (First, Middle, Maiden Surname) ADALINE ADAMS			
19a. INFORMANT'S NAME (Type/Print) JOHN HNAT				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5408 CHATSWORTH COURT, FAIRFAX, VIRGINIA 22032			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) METROPOLITAN CREMATORY		DATE 4/15/95		20c. LOCATION — City or Town, State ALEXANDRIA, VA.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY MURPHY FUNERAL HOME, INC. 4510 WILSON BLVD. ARL. VA. 22203			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>HEPATIC-RENAL FAILURE</u> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death 2 weeks
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D-43700		29d. DATE SIGNED (Month, Day, Year) 12 APR 95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) T.S. KNEE, LCDR, MC, USNR NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600							
31. DATE FILED (Month, Day, Year) APR 17 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13758

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Velma Arlene Heine				2. DATE OF DEATH MONTH April DAY 19 YEAR 1995				3. TIME OF DEATH 7:55 p M	
4. SOCIAL SECURITY NUMBER 343.10.2532		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 78 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) Jan. 16, 1917	
8. BIRTHPLACE (State or Foreign Country) Illinois				9a. FACILITY NAME (If not institution, give street and number) Shady Grove Nursing Home				9b. CITY, TOWN OR LOCATION OF DEATH Rockville	
9c. COUNTY OF DEATH Montgomery				10a. STATE Maryland				10b. COUNTY Montgomery	
10c. CITY, TOWN OR LOCATION Derwood				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 7204 Blanchard Drive	
10f. ZIP CODE 20855				10g. CITIZEN OF WHAT COUNTRY? U.S.A.				11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) +4				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Secretary				16b. KIND OF BUSINESS/INDUSTRY State Department	
17. FATHER'S NAME (First, Middle, Last) Ross J. Scaggs				18. MOTHER'S NAME (First, Middle, Maiden Surname) Inez Ethel Zehner				19a. INFORMANT'S NAME (Type/Print) Carol Lee Martin	
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 35th Avenue Kenosha, WI 53144				20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MT. Comfort Crematory 4-24-95	
20c. LOCATION — City or Town, State Alexandria, Va.				21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John M. Peters</i>				22. NAME AND ADDRESS OF FACILITY Joseph Gawler's Sons 5130 Wisconsin Ave. N.W. Washington D.C.	
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → CEREBRO VASCULAR ACCIDENT a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate interval Between Onset and Death 4 WEEKS								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO								25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide	
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
29b. SIGNATURE AND TITLE OF CERTIFIER <i>P. Talwar</i>				29c. LICENSE NUMBER D 36552				29d. DATE SIGNED (Month, Day, Year) APRIL 19, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Pankaj Talwar, M.D. 50 W Edmonston Dr. #401 Rockville, Md. 20852									
31. DATE FILED (Month, Day, Year) APR 21 1995				32. REGISTRAR'S SIGNATURE <i>John Pankaj Talwar</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95-2203-003

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ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-724 6/5/95 t.t

95 13759

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Mark T Harper Jr.				2. DATE OF DEATH MONTH DAY YEAR April 15 1995		3. TIME OF DEATH 0250	
4. SOCIAL SECURITY NUMBER 448-90-0943		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 21 YRS.		7. DATE OF BIRTH (Month, Day, Year) JULY 11, 1973	
9a. FACILITY NAME (If not institution, give street and number) Anne Arundel General Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Annapolis		9c. COUNTY OF DEATH Anne Arundel	
10a. STATE OK.		10b. COUNTY OKLAHOMA		10c. CITY, TOWN OR LOCATION MIDWEST		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 817 FAIRLANE DR.				10f. ZIP CODE 73110		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES ACTIVE DUTY		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) 4		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) U.S. NAVY		16b. KIND OF BUSINESS/INDUSTRY DEFENSE			
17. FATHER'S NAME (First, Middle, Last) MARK THOMAS HARPER				18. MOTHER'S NAME (First, Middle, Maiden Surname) MERINDA MADDEN			
19a. INFORMANT'S NAME (Type/Print) MARK T. HARPER				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) SAME AS ITEM #10			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) RETHAVEN MEM. GARDENS 4/21		20c. LOCATION — City or Town, State SEMINOLE, OK.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE W. W. Chambers M00091				22. NAME AND ADDRESS OF FACILITY W. W. CHAMBERS CO., RIVERDALE, MD. 20737			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → MULTIPLE INJURIES DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) 4-15-95		28b. TIME OF INJURY 2 A M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED DRIVER OF AUTO THAT OVERTURNED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) ROAD		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) EASTPORT, ANNAPOLIS, MD.	
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Charles D. McKel				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) APRIL 15/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) HARPER P. HOBBS JR. 111 PENN STREET, BALTIMORE, MARYLAND 21201							
31. DATE FILED (Month, Day, Year) APR 21 1995				32. REGISTRAR'S SIGNATURE John Davidson			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Amended #196, 4/27/95 MRT Montgomery County 9504760
 Amended #1, 4/21/95, JW, Montgomery County 9504760

1 -
 FOR
 STATE
 REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Vivian Louretta Houk</i> <i>Viviane Louretta Houk</i>				2. DATE OF DEATH April 19, 1995 DAY YEAR		3. TIME OF DEATH 2:10 P M	
4. SOCIAL SECURITY NUMBER 235-14-1992		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (in yrs. last birthday) 77 YRS.		7. DATE OF BIRTH (Month, Day, Year) Sept. 2, 1917	
8. BIRTHPLACE (State or Foreign Country) West Virginia		9a. FACILITY NAME (If not institution, give street and number) Holy Cross Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring		9c. COUNTY OF DEATH Montgomery	
10a. STATE Maryland		10b. COUNTY Howard		10c. CITY, TOWN OR LOCATION Woodbine		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 3661 Jennings Chapel Road				10f. ZIP CODE 21797		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home	
17. FATHER'S NAME (First, Middle, Last) James William Judge				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Margaret Gorby			
19a. INFORMANT'S NAME (Type/Print) Albert E. H. Houk				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3661 Jennings Chapel Rd, Woodbine, MD 21797			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) National Memorial Park 4/24/95		20c. LOCATION — City or Town, State Falls Church, VA		21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Steven J. Stroud</i>	
22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd. W. Silver Spring, MD 20901							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Hepato-renal failure</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>Cirrhosis</i> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death 3 days long - steady							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Paul K. [Signature]</i> MD				29c. LICENSE NUMBER 021435		29d. DATE SIGNED (Month, Day, Year) April 19 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Paul K. [Signature] 2101 Medical Park Dr Silver Spring, Md 20902							
31. DATE FILED (Month, Day, Year) APR 21 1995							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

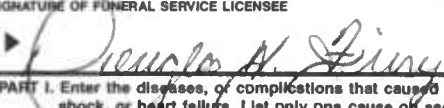

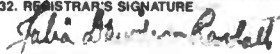
DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
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 IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13761

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) HELEN Louise HAUGH				2. DATE OF DEATH MONTH DAY YEAR APRIL 25, 1995		3. TIME OF DEATH 6:06 A^M	
4. SOCIAL SECURITY NUMBER 216-46-8199		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 88 YRS.		7. DATE OF BIRTH (Month, Day, Year) 4-24-1907	
9a. FACILITY NAME (If not institution, give street and number) Williamsport Nursing Home				9b. CITY, TOWN OR LOCATION OF DEATH Williamsport		9c. COUNTY OF DEATH Washington	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Washington		10c. CITY, TOWN OR LOCATION Hagerstown		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 1411 Potomac Avenue				10f. ZIP CODE 21742		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 years		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Personal Residence			
17. FATHER'S NAME (First, Middle, Last) David H. Flory Jr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ruth Johnson			
19a. INFORMANT'S NAME (Type/Print) Joann E. Carroll Haugh				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 425 Summitt Avenue Hagerstown, Md. 21740			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) St. Paul's Cemetery		20c. LOCATION — City or Town, State Clear Spring, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Douglas A. Fiery Funeral Home 1331 Eastern Blvd. Hagerstown, Md. 21742			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ACUTE MYOCARDIAL INFARCTION DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate Interval Between Onset and Death 10 MINS.	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D 33700		29d. DATE SIGNED (Month, Day, Year) APRIL 25, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) TED E. HOWE, M.D., 154 NORTH ARTIZAN STREET, WILLIAMSPORT, MD 21795							
31. DATE FILED (Month, Day, Year) APR 26 1995		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13762

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Malcolm Frederick Hose				2. DATE OF DEATH MONTH 04 DAY 19 YEAR 95		3. TIME OF DEATH 0240 A.M.	
4. SOCIAL SECURITY NUMBER 220-05-6789A		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		8. AGE (In yrs. last birthday) 82 YRS.		7. DATE OF BIRTH (Month, Day, Year) Dec. 19, 1912	
9a. FACILITY NAME (If not institution, give street and number) Washington County Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Hagerstown		9c. COUNTY OF DEATH WA. Wash.	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Washington		10c. CITY, TOWN OR LOCATION Hagerstown		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 878 Frederick Street				10f. ZIP CODE 21740		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) machinist		15b. KIND OF BUSINESS/INDUSTRY sand blasting			
17. FATHER'S NAME (First, Middle, Last) Nelvie Hose				16. MOTHER'S NAME (First, Middle, Maiden Surname) Lillie Carbaugh			
19a. INFORMANT'S NAME (Type/Print) Jane Dorsey				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Broadfording Cemetery 4-22-95		DATE		20c. LOCATION — City or Town, State Hagerstown, Marylande	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Scott Minnick</i>				22. NAME AND ADDRESS OF FACILITY MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Brain Stem Infarct (Cerebral)</i>							
DUE TO (OR AS A CONSEQUENCE OF): <i>Chronic Hypertension</i>							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
DUE TO (OR AS A CONSEQUENCE OF): <i>Arteriosclerotic Heart Disease</i>							
DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Chronic Obstructive Pulmonary Disease</i> <i>Long-term use of drugs</i>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Edward H. Moody</i>				29c. LICENSE NUMBER 007857		29d. DATE SIGNED (Month, Day, Year) 4/19/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. E.B. Moody 1190 Mt. Arctna Road Hagerstown Md 21740							
31. DATE FILED (Month, Day, Year) APR 20 1995				32. REGISTRAR'S SIGNATURE <i>J. B. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



25

Handwritten text at the bottom center, possibly a signature or date.

95 13763

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Margaret Lee HOWARD				2. DATE OF DEATH MONTH DAY YEAR 04 - 14 - 95				3. TIME OF DEATH 0830 M					
4. SOCIAL SECURITY NUMBER 214-09-1936		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 81 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) Sept. 18, 1913		8. BIRTHPLACE (State or Foreign Country) New York			
9a. FACILITY NAME (If not institution, give street and number) 2750 Virginia Avenue				9b. CITY, TOWN OR LOCATION OF DEATH Williamsport				9c. COUNTY OF DEATH Washington					
10a. STATE Maryland		10b. COUNTY Washington		10c. CITY, TOWN OR LOCATION Williamsport				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO					
10e. STREET AND NUMBER 2750 Virginia Avenue				10f. ZIP CODE 21795				10g. CITIZEN OF WHAT COUNTRY? USA					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: white					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) secretary				16b. KIND OF BUSINESS/INDUSTRY Retail paints					
17. FATHER'S NAME (First, Middle, Last) Otto Perry Bohman				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mabel Pyles									
19a. INFORMANT'S NAME (Type/Print) Margaret B. Howard				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) pre-arrangements- 2750 Virginia Avenue Williamsport, Md. 21795									
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Rose Hill Cemetery 4-17-95				20c. LOCATION — City or Town, State Hagerstown, Maryland					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Scott Minnick				22. NAME AND ADDRESS OF FACILITY MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ACUTE MYOCARDIAL INFARCTION DUE TO (OR AS A CONSEQUENCE OF): b. ARTERIOSCLEROTIC HEART DISEASE DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. SEQUENTIALLY LIST CONDITIONS, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST										Approximate interval Between Onset and Death SUDDEN YEARS			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. NONE										24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) NONE		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28i. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER [Signature]						29c. LICENSE NUMBER D01040		29d. DATE SIGNED (Month, Day, Year) 04-14-95					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) BARRY M. COHEN, MD, 18706 CRESTWOOD DR, HAGERSTOWN, MD 21742													
31. DATE FILED (Month, Day, Year) APR 17 1995				32. REGISTRAR'S SIGNATURE John [Signature]									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13764

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Hypatia Virginia HOTT				2. DATE OF DEATH MONTH DAY YEAR April 25 1995		3. TIME OF DEATH 0916 P.M.	
4. SOCIAL SECURITY NUMBER 216-14-5687		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 73 YRS.	7. DATE OF BIRTH (Month, Day, Year) Sep. 2, 1921		8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not institution, give street and number) Washington County Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Hagerstown		9c. COUNTY OF DEATH Washington	
10a. STATE Maryland		10b. COUNTY Washington		10c. CITY, TOWN OR LOCATION Williamsport		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 15215 Saber Rd.				10f. ZIP CODE 21795		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+) 9		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Seamstress		16b. KIND OF BUSINESS/INDUSTRY Clothing Manufacture			
17. FATHER'S NAME (First, Middle, Last) James Lesley Keeney				18. MOTHER'S NAME (First, Middle, Maiden Surname) Minnie Belle Wetzel			
19a. INFORMANT'S NAME (Type/Print) Donald L. Hott				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1359 State Line Rd. Waynesboro, PA 17268			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Greenlawn Memorial Park April 28, 1995		20c. LOCATION — City or Town, State Williamsport, MD 21795		20d. DATE April 28, 1995	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY OSBORNE FUNERAL HOME P.O. Box # 348 Williamsport, MD 21795			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ACUTE MYOCARDIAL INFARCTION DUE TO (OR AS A CONSEQUENCE OF): b. CORONARY ARTERY DISEASE DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death 1 day							
23. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETES MELLITUS, HYPERTENSION, MULT- INFARCT DEMENTIA DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D38892		29d. DATE SIGNED (Month, Day, Year) 4/26/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ANGELA FOX BRADFORD MD 1797 HOWELL RD HAGERSTOWN, MD 21740							
31. DATE FILED (Month, Day, Year) APR 27 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13765

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Elmer Guy HENDERSHOT				2. DATE OF DEATH MONTH April DAY 21 YEAR 1995		3. TIME OF DEATH 9:10 A.M.	
4. SOCIAL SECURITY NUMBER 235-34-6082		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 73 YRS.		7. DATE OF BIRTH (Month, Day, Year) Oct. 20, 1921	
9a. FACILITY NAME (If not institution, give street and number) Washington County Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Hagerstown		9c. COUNTY OF DEATH Washington	
10a. STATE Maryland				10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Rockville	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 13200 Magellan Ave.			
10f. ZIP CODE 20853				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES W.W. II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 6				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Elementary School Teacher		16b. KIND OF BUSINESS/INDUSTRY Public Schools	
17. FATHER'S NAME (First, Middle, Last) Clyde Hendershot				18. MOTHER'S NAME (First, Middle, Maiden Surname) Rebecca Cross			
19a. INFORMANT'S NAME (Type/Print) Nancy Beall				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2408 Doubs Ct., Adamstown, Md. 21710			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Woodlawn Cemetery		20c. LOCATION — City or Town, State Fairmont, West Va.		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Scott Minnich</i>				22. NAME AND ADDRESS OF FACILITY MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute Respiratory Failure DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. Chronic obstructive pulmonary disease DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____							Approximate Interval Between Onset and Death 1 Hr Years
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							24c. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DCA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Q. Healy</i>				29c. LICENSE NUMBER D21457		29d. DATE SIGNED (Month, Day, Year) 4/21/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ABDUL WAHED 140, 12821-OAKHILL AVE. HAGERSTOWN. MD							
31. DATE FILED (Month, Day, Year) APR 24 1995				32. REGISTRAR'S SIGNATURE <i>John Andrew Beall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

100-100-100

95 13766

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Elizabeth Irene Harris				2. DATE OF DEATH MONTH April DAY 19 YEAR 1995		3. TIME OF DEATH 12:36 P M	
4. SOCIAL SECURITY NUMBER 215-28-6737		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 64 YRS.		7. DATE OF BIRTH (Month, Day, Year) Nov. 8, 1930	
9a. FACILITY NAME (If not institution, give street and number) Fallston General Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Fallston		9c. COUNTY OF DEATH Harford	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Harford		10c. CITY, TOWN OR LOCATION Edgewood		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 621 Hartwood Lane				10f. ZIP CODE 21040		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Home			
17. FATHER'S NAME (First, Middle, Last) Paul Francis Greiner				18. MOTHER'S NAME (First, Middle, Maiden Surname) Anna Lola Hughes			
19a. INFORMANT'S NAME (Type/Print) Eugene Harris				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 621 Hartwood Lane, Edgewood, Maryland 21040			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) Bel Air Memorial Gardens 4/22/95 Bel Air, Maryland		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Stephen A. Hughes</i>				22. NAME AND ADDRESS OF FACILITY Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Md. 21009			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. Central brainstem herniation					Approximate Interval Between Onset and Death 24 hrs.
		b. Increased intracranial pressure					36 hrs.
		c. Cerebral hemorrhage					38 hrs.
		d. Hypertension					1 1/2 yrs
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED					
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Harvey B. Pats M.D.</i>				29c. LICENSE NUMBER D19238		29d. DATE SIGNED (Month, Day, Year) APRIL 19, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) HARVEY B. PATS M.D. 2 COLGATE DR. SUITE 201 Forest Hill, Md. 21050							
31. DATE FILED (Month, Day, Year) APR 21 1995				32. REGISTRAR'S SIGNATURE <i>John A. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020




TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13767

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) CECELIA Jane HOOD				2. DATE OF DEATH MONTH DAY YEAR APRIL 14 1995				3. TIME OF DEATH 0240 A					
4. SOCIAL SECURITY NUMBER 214-10-2089		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) 78 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) 10-10-16		8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not institution, give street and number) Anne Arundel Medical Center						9b. CITY, TOWN OR LOCATION OF DEATH Annapolis				9c. COUNTY OF DEATH Anne Arundel			
10a. STATE Maryland				10b. COUNTY Anne Arundel				10c. CITY, TOWN OR LOCATION Annapolis				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER College Parkway Place						10f. ZIP CODE 21401				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: white			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Secretary				16b. KIND OF BUSINESS/INDUSTRY American Red Cross					
17. FATHER'S NAME (First, Middle, Last) Howard Colliflower						18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Helen Unknown							
19a. INFORMANT'S NAME (Type/Print) William H. Hood						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 111 Holly Court Stevensville, MD 21666							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Prospect Cemetery 4-18-95				20c. LOCATION — City or Town, State Mt. Airey, MD					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 						22. NAME AND ADDRESS OF FACILITY Barranco and Sons Funeral Home 495 Ritchie Hwy Severna Park MD 21146							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Septic Shock DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { b. Streptococcus pneumoniae bacteremia DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER 124604		29d. DATE SIGNED (Month, Day, Year) 4-14-95			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) GOO Robert T. Barranco Annapolis MD 21401													
31. DATE FILED (Month, Day, Year) APR 21 1995				32. REGISTRAR'S SIGNATURE 									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13768

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) John H. Hupp				2. DATE OF DEATH MONTH DAY YEAR April 14 1995				3. TIME OF DEATH 2:45A M	
4. SOCIAL SECURITY NUMBER 216-30-9951		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 60 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Nov 23 1934		8. BIRTHPLACE (State or Foreign Country) West Virginia	
9a. FACILITY NAME (If not institution, give street and number) 1248 Tyler Avenue				9b. CITY, TOWN OR LOCATION OF DEATH Annapolis			9c. COUNTY OF DEATH Anne Arundel		
10a. STATE MD		10b. COUNTY Anne Arundel		10c. CITY, TOWN OR LOCATION Annapolis			10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		
10e. STREET AND NUMBER 1248 Tyler Avenue				10f. ZIP CODE 21403		10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Plumber			16b. KIND OF BUSINESS/INDUSTRY Plumbing				
17. FATHER'S NAME (First, Middle, Last) John W. Hupp				18. MOTHER'S NAME (First, Middle, Maiden Surname) Margaret Collins					
19a. INFORMANT'S NAME (Type/Print) Gertrude Hupp				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1248 Tyler Avenue Annapolis, Maryland 21403					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Hillcrest Cemetery 4/17/95		DATE 4/17/95		20c. LOCATION — City or Town, State Annapolis, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Donald A. Lutz</i>				22. NAME AND ADDRESS OF FACILITY John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastatic lung cancer DUE TO (OR AS A CONSEQUENCE OF): b. Liver metastases DUE TO (OR AS A CONSEQUENCE OF): c. Bone metastases DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death 1 yr Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO									
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO									
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Ann C. Massey, M.D.</i>				29c. LICENSE NUMBER D44465		29d. DATE SIGNED (Month, Day, Year) 4/14/95			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Ann C. Massey, M.D. 900 Bestgate Rd, Suite 300, Annapolis, MD 21401									
31. DATE FILED (Month, Day, Year) APR 19 1995				32. REGISTRAR'S SIGNATURE <i>Julia Davidson Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL, DR. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

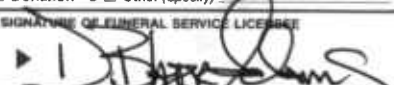
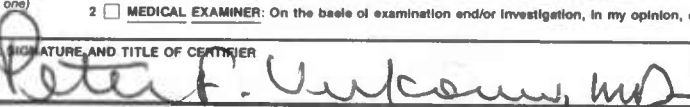
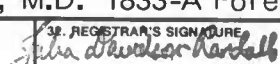
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13769

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Edwin Malburn Hall				2. DATE OF DEATH MONTH DAY YEAR April 13 1995		3. TIME OF DEATH 1:20AM M	
4. SOCIAL SECURITY NUMBER 220-44-4447		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 85 YRS.		7. DATE OF BIRTH (Month, Day, Year) April 18 1909	
9a. FACILITY NAME (If not institution, give street and number) Meridian Health Care Center/Spa Creek				9b. CITY, TOWN OR LOCATION OF DEATH Annapolis		9c. COUNTY OF DEATH Anne Arundel	
10a. STATE MD		10b. COUNTY Anne Arundel		10c. CITY, TOWN OR LOCATION Annapolis		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 1305 Van Buren Drive				10f. ZIP CODE 21403		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWI		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yee or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) 6		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Professor		15b. KIND OF BUSINESS/INDUSTRY United States Naval Academy			
17. FATHER'S NAME (First, Middle, Last) Edwin Hall				18. MOTHER'S NAME (First, Middle, Maiden Surname) Laura Malburn			
19a. INFORMANT'S NAME (Type/Print) Charles M. Grayston				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1305 Van Buren Drive Annapolis, Maryland 21403			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) St. Margaret's Cemetery 4/17/95		DATE 4/17/95		20c. LOCATION — City or Town, State Annapolis, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Longestroke Heart failure DUE TO (OR AS A CONSEQUENCE OF): Dilated arteriosclerotic Cardiomyopathy Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): Dementia							Approximate Interval Between Onset and Death 3 mos
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, lecture, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER  Peter F. Verkouw, M.D.				29c. LICENSE NUMBER D11653		29d. DATE SIGNED (Month, Day, Year) April 13 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Peter F. Verkouw, M.D. 1833-A Forest Drive Annapolis, MD 21401 (410-267-9211)							
31. DATE FILED (Month, Day, Year) APR 14 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

AMENDED #1 and #16B, 4/17/95, B.P., WORCESTER CO.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

1. DECEDENT'S NAME (First, Middle, Last) William A. Huss		2. DATE OF DEATH MONTH APRIL DAY 16 YEAR 1995		3. TIME OF DEATH 0908	
4. SOCIAL SECURITY NUMBER 133-14-7754		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 67 YRS.	
7. DATE OF BIRTH 4-19-27		8. BIRTHPLACE (State or Foreign Country) NY			
9a. FACILITY NAME (If not institution, give street and number) ATLANTIC GENERAL HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH BERLIN		9c. COUNTY OF DEATH WORCESTER	
RESIDENCE OF DECEDENT					
10a. STATE MD.		10b. COUNTY WORCESTER		10c. CITY, TOWN OR LOCATION BERLIN	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
10e. STREET AND NUMBER 735 OCEAN PARKWAY		10f. ZIP CODE 21811		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:	
14. RACE — American Indian, Black, White, etc. Specify: WHITE					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5 +)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) COURT OFFICER		16b. KIND OF BUSINESS/INDUSTRY COUNTY GOVERNMENT	
17. FATHER'S NAME (First, Middle, Last) CHRISTOPHER HUSS		18. MOTHER'S NAME (First, Middle, Maiden Surname) ETHEL HARMAR			
19a. INFORMANT'S NAME (Type/Print) LORE G. HUSS		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4885 OCEAN PINES BERLIN, MD., 21811			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) SALISBURY CREMATORY 4-18		20c. LOCATION — City or Town, State SALISBURY, MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John Ullrich</i>		22. NAME AND ADDRESS OF FACILITY ULLRICH FUNERAL HOME BERLIN, MD.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. Stroke DUE TO (OR AS A CONSEQUENCE OF):		Approximate Interval Between Onset and Death 4 days	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST		b. Lung Cancer DUE TO (OR AS A CONSEQUENCE OF):		5 weeks	
		c. Coronary Artery Disease DUE TO (OR AS A CONSEQUENCE OF):			
		d.			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER Bill Greer, MD		29c. LICENSE NUMBER D-35764		29d. DATE SIGNED (Month, Day, Year) 4/16/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Bill Greer, MD 3 Bay Street Berlin, Md. 21811					
31. DATE FILED (Month, Day, Year) APR 17 1995		32. REGISTRAR'S SIGNATURE <i>John S. Randolph</i>			

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

IMPORTANT: If item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

95 13771

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) John Leonard Iverson				2. DATE OF DEATH MONTH DAY YEAR April 21 1995		3. TIME OF DEATH 10:00 AM	
4. SOCIAL SECURITY NUMBER 476-16-8908		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 72 YRS.		7. DATE OF BIRTH (Month, Day, Year) 3/15/1923	
9a. FACILITY NAME (If not institution, give street and number) 1207 Senorita Court				9b. CITY, TOWN OR LOCATION OF DEATH Westminster		9c. COUNTY OF DEATH Carroll	
10a. STATE Maryland				10b. COUNTY Carroll		10c. CITY, TOWN OR LOCATION Westminster	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 1207 Senorita Court		10f. ZIP CODE 21157	
10g. CITIZEN OF WHAT COUNTRY? United States				11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: white			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) chemist		16b. KIND OF BUSINESS/INDUSTRY Food & Drug Administration	
17. FATHER'S NAME (First, Middle, Last) Emil Iverson				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ina Delemater			
19a. INFORMANT'S NAME (Type/Print) Hattie Louise Iverson				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1207 Senorita Ct., Westminster, MD 21157			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Maryland Veteran's Cemetery 4/25/95 DATE		20c. LOCATION — City or Town, State Hurlock, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Katherine Pitts-Sweitzer				22. NAME AND ADDRESS OF FACILITY Pritts Funeral Home & Chapel 412 Washington Rd., Westminster, MD			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Respiratory Failure							
DUE TO (OR AS A CONSEQUENCE OF): b. Chronic Myelogenous Leukemia							
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST c. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Insulin Dependent Diabetes							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Peter B. Sherer MD				29c. LICENSE NUMBER D21910		29d. DATE SIGNED (Month, Day, Year) April 21, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Peter B. Sherer MD 3947 Ferrara Dr. Wheaton, MD 20906							
31. DATE FILED (Month, Day, Year) APR 24 1995				32. REGISTRAR'S SIGNATURE John A. Anderson			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

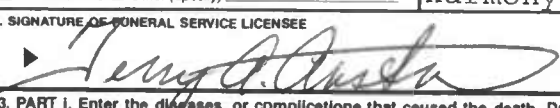
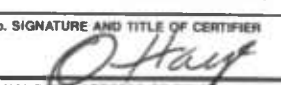
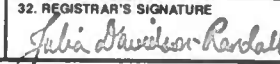
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13772

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Julia Isaacs				2. DATE OF DEATH MONTH April DAY 7, 1995 YEAR		3. TIME OF DEATH 9:44 A M	
4. SOCIAL SECURITY NUMBER 239-14-4445		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 80 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 1915 January 29, S. Carolina	
9a. FACILITY NAME (If not institution, give street and number) Southern Maryland Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Clinton		9c. COUNTY OF DEATH Prince Georges	
10a. STATE Maryland		10b. COUNTY Prince Georges		10c. CITY, TOWN OR LOCATION Upper Marlboro		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 3803 Halloway Circle				10f. ZIP CODE 20772		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9th College (1-4 or 5+) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Presser		16b. KIND OF BUSINESS/INDUSTRY Laundry			
17. FATHER'S NAME (First, Middle, Last) Stout Pope				18. MOTHER'S NAME (First, Middle, Maiden Surname) Rosa Lee			
19a. INFORMANT'S NAME (Type/Print) Irene Washington				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3803 Halloway Circle, Upper Marlboro, MD. 20772			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Harmony Memorial Park 4/15/95		DATE Landover, MD.		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Austin Royster Funeral Home 3605 14th St. N.W. Wash, DC. 20010			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Aspiration Pneumonitis DUE TO (OR AS A CONSEQUENCE OF): b. Peripheral Vascular Disease DUE TO (OR AS A CONSEQUENCE OF): c. COPD DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death 12hor Months							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER D26352		29d. DATE SIGNED (Month, Day, Year) April 7, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) O. Hays 9131 Piscataway Road, Clinton, Maryland 20735							
31. DATE FILED (Month, Day, Year) APR 17 1995		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13773

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Robert Charles Johnston Sr.				2. DATE OF DEATH MONTH April DAY 20 YEAR 1995		3. TIME OF DEATH 11:45 P.M.	
4. SOCIAL SECURITY NUMBER 216-24-8829		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 64 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 1, 1930	
8. FACILITY NAME (If not institution, give street and number) Harford Memorial Hospital				9. CITY, TOWN OR LOCATION OF DEATH Harre de Grace		10. COUNTY OF DEATH Harford	
10a. STATE Maryland		10b. COUNTY Harford		10c. CITY, TOWN OR LOCATION Aberdeen		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 53 Swan Street				10f. ZIP CODE 21001		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES Korea		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 0		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Warehouseman		16b. KIND OF BUSINESS/INDUSTRY U.S. Government			
17. FATHER'S NAME (First, Middle, Last) Frederick Johnston				18. MOTHER'S NAME (First, Middle, Maiden Surname) Sarah E. Lewis			
19a. INFORMANT'S NAME (Type/Print) Mrs. Mabel C. Johnston				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 53 Swan Street, Aberdeen, Maryland			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Salem Cemetery		20c. DATE 4/24		20d. LOCATION — City or Town, State Delta, Pennsylvania	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ray R. Di Giovanni				22. NAME AND ADDRESS OF FACILITY Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Brain Tumor (Glioblastoma Multiforme) DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Harford Memorial Hospital					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURRED Hospital			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER John A. Anderson MD		29c. LICENSE NUMBER 046412		29d. DATE SIGNED (Month, Day, Year) 4/21/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 319 S. Union Ave Harre de Grace Md 21078							
31. DATE FILED (Month, Day, Year) 4 APR 24 1995		32. REGISTRAR'S SIGNATURE John A. Anderson					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13774

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Frances A Jenkins</i>				2. DATE OF DEATH MONTH <i>April</i> DAY <i>16</i> YEAR <i>95</i>		3. TIME OF DEATH <i>6:58 A M</i>	
4. SOCIAL SECURITY NUMBER <i>578-22-4684</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <i>72</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7. DATE OF BIRTH (Month, Day, Year) <i>Feb. 24, 1923</i>				8. BIRTHPLACE (State or Foreign Country) <i>Maryland</i>			
9a. FACILITY NAME (If not institution, give street and number) <i>Holy Cross Hospital</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Silver Spring</i>		9c. COUNTY OF DEATH <i>Montgomery</i>	
10a. STATE <i>Maryland</i>				10b. COUNTY <i>Montgomery</i>		10c. CITY, TOWN OR LOCATION <i>Silver Spring</i>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER <i>15104 Hildegard Lane</i>				10f. ZIP CODE <i>20905</i>		10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>10</i> College (1-4 or 5+) <i></i>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Printer</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Printing</i>	
17. FATHER'S NAME (First, Middle, Last) <i>Raymond Case</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Sophia Moore</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Charlotte A. Gatton</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>15104 Hildegard Lane, Silver Spring, MD 20905</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Parklawn Cemetery 4/19/95</i>		20c. LOCATION — City or Town, State <i>Rockville, MD</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Steven D Stroud</i>				22. NAME AND ADDRESS OF FACILITY <i>Francis J. Collins Funeral Home, Inc. 500 University Blvd. W. Sil. Spr. MD 20901</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>a. acute inferior wall myocardial infarction</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death <i>3d</i>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Michael Lincoln</i>				29c. LICENSE NUMBER <i>029293</i>		29d. DATE SIGNED (Month, Day, Year) <i>4/14/95</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Michael Lincoln, M.D. 10313 Georgia Ave Silver Spring, MD 20902</i>							
31. DATE FILED (Month, Day, Year) <i>APR 18 1995</i>				32. REGISTRAR'S SIGNATURE <i>John Andrew Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13775

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) <i>John E. Johnson</i>				2. DATE OF DEATH MONTH <i>April</i> DAY <i>16</i> YEAR <i>95</i>		3. TIME OF DEATH <i>8:04 PM</i>	
4. SOCIAL SECURITY NUMBER <i>216-50-8111</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>47</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>July 19, 1947</i>	
8. BIRTHPLACE (State or Foreign Country) <i>Tennessee</i>				9. FACILITY NAME (If not institution, give street and number) <i>Holy Cross Hospital</i>		10. CITY, TOWN OR LOCATION OF DEATH <i>Silver Spring</i>	
11. COUNTY OF DEATH <i>Montgomery</i>				12. STATE <i>Maryland</i>		13. CITY, TOWN OR LOCATION <i>Silver Spring</i>	
14. STREET AND NUMBER <i>7 Normandy Drive</i>				15. ZIP CODE <i>20901</i>		16. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
17. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced				18. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			
19. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				20. RACE — American Indian, Black, White, etc. Specify: <i>White</i>			
21. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>4</i> College (1-4 or 5+) <i>4</i>				22. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Programer</i>			
23. KIND OF BUSINESS/INDUSTRY <i>Computers</i>				24. FATHER'S NAME (First, Middle, Last) <i>Robert E. Johnson</i>			
25. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Doris A. Richardson</i>				26. INFORMANT'S NAME (Type/Print) <i>Alice A. Wade</i>			
27. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>7 Normandy Drive, Silver Spring, MD 20901</i>				28. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			
29. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Gate of Heaven Cemetery 4/20/95</i>				30. LOCATION — City or Town, State <i>Silver Spring, MD</i>			
31. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Robert E. Ramsey</i>				32. NAME AND ADDRESS OF FACILITY <i>Francis J. Collins Funeral Home, Inc. 500 University Blvd. W. Silver Spring, MD 20901</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>a. arteriosclerotic heart disease</i> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximately Interval Between Onset and Death							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28. DATE OF INJURY (Month, Day, Year) <i>4/16/95</i>			
29. TIME OF INJURY <i>M</i>				30. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
31. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				32. DESCRIBE HOW INJURY OCCURRED			
33. LOCATION (Street and Number or Rural Route Number, City or Town, State)				34. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
35. SIGNATURE AND TITLE OF CERTIFIER <i>John T. ... MD</i>				36. LICENSE NUMBER <i>208546</i>			
37. DATE SIGNED (Month, Day, Year) <i>April 16 95</i>				38. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>John T. ... 8718 Wisconsin Ave Bethesda</i>			
39. DATE FILED (Month, Day, Year) <i>APR 20 1995</i>				40. REGISTRAR'S SIGNATURE <i>Julia Davidson Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Amended #1, KB, 4-17-95, Wash-Co-Hosp 13776

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Janet C. JONES				2. DATE OF DEATH MONTH DAY YEAR April 14, 1995				3. TIME OF DEATH 5:15 p M	
4. SOCIAL SECURITY NUMBER 577-38-5539		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 96 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7. DATE OF BIRTH (Month, Day, Year) Sept. 26, 1898				8. BIRTHPLACE (State or Foreign Country) Pennsylvania					
9a. FACILITY NAME (If not institution, give street and number) Avalon Manor Nursing Home				9b. CITY, TOWN OR LOCATION OF DEATH Hagerstown				9c. COUNTY OF DEATH Washington	
RESIDENCE OF DECEDENT									
10a. STATE Maryland		10b. COUNTY Washington		10c. CITY, TOWN OR LOCATION Hagerstown				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 2309 Grandview Drive				10f. ZIP CODE 21740				10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 5				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) General Accounting				16b. KIND OF BUSINESS/INDUSTRY Federal Government	
17. FATHER'S NAME (First, Middle, Last) William Crawford				18. MOTHER'S NAME (First, Middle, Maiden Surname) Hannah Ritchie					
19a. INFORMANT'S NAME (Type/Print) Antionette V. Light				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2308 Grandview Drive Hagerstown, Md. 21740					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Everett Cemetery 4-17-95				20c. LOCATION — City or Town, State Everett, Pennsylvania	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Scott Munnick				22. NAME AND ADDRESS OF FACILITY Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 21740					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sudden Cardiac Arrest Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Coronary Artery Disease Atherosclerotic Cardiovascular Disease								Approximate Interval Between Onset and Death 1 hr 7 hr 9 hr	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide					
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER [Signature]				29c. LICENSE NUMBER D18015				29d. DATE SIGNED (Month, Day, Year) April 15, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) VASANT DATTA MD 330 MILL ST HAGERSTOWN MD 21740									
31. DATE FILED (Month, Day, Year) APR 17 1995				32. REGISTRAR'S SIGNATURE [Signature]					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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95 13777

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Dorothy Elizabeth JACKSON</i>				2. DATE OF DEATH MONTH <i>April</i> DAY <i>10</i> YEAR <i>1995</i>		3. TIME OF DEATH <i>1345 P M</i>	
4. SOCIAL SECURITY NUMBER <i>177-24-7385</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <i>64</i> YRS.	7. DATE OF BIRTH (Month, Day, Year) <i>Sept. 28, 1930</i>		8. BIRTHPLACE (State or Foreign Country) <i>Maryland</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Washington County Hospital</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Hagerstown</i>		9c. COUNTY OF DEATH <i>Washington</i>	
10a. STATE <i>Maryland</i>		10b. COUNTY <i>Washington</i>		10c. CITY, TOWN OR LOCATION <i>Hagerstown</i>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <i>1105 Salem Avenue</i>				10f. ZIP CODE <i>21740</i>		10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>8</i> College (1-4 or 5+) <i>0</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Machine Operator</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Clothing Manufacturer</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Wesley Edwin Bingham</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Leona Margaret Mowen</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Wilfred C. Jackson</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1105 Salem Avenue Hagerstown, Maryland 21740</i>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Cedar Lawn Memorial Park 4-13-95</i>		20c. LOCATION — City or Town, State <i>Hagerstown, Maryland</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Scott Minnick</i>				22. NAME AND ADDRESS OF FACILITY <i>Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 21740</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>a. Acute myelogenous leukemia</i> DUE TO (OR AS A CONSEQUENCE OF): <i>b. Polycythemia vera</i> DUE TO (OR AS A CONSEQUENCE OF): <i>c.</i> DUE TO (OR AS A CONSEQUENCE OF): <i>d.</i> Approximate Interval Between Onset and Death <i>13 years</i>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURRED			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Frederick H. Kass III MD</i>				29c. LICENSE NUMBER <i>023622</i>		29d. DATE SIGNED (Month, Day, Year) <i>4/10/95</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Frederick H. Kass III MD 1799 Howell Rd Hagerstown</i>							
31. DATE FILED (Month, Day, Year) <i>APR 12 1995</i>		32. REGISTRAR'S SIGNATURE <i>John A. [Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13778

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) NANCY Daughtry JENKINS				2. DATE OF DEATH MONTH DAY YEAR APRIL 11, 1995		3. TIME OF DEATH 9:38A	
4. SOCIAL SECURITY NUMBER 224-38-9839		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (in yrs. last birthday) 62 YRS.		7. DATE OF BIRTH MONTH DAY YEAR OCT. 14, 1932	
8. BIRTHPLACE (State or Foreign Country) Va.		9a. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY		9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Worcester		10c. CITY, TOWN OR LOCATION Pocomoke		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 711 Short Street				10f. ZIP CODE 21851		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Domestic		16b. KIND OF BUSINESS/INDUSTRY Housewife			
17. FATHER'S NAME (First, Middle, Last) Daniel Daughtry				18. MOTHER'S NAME (First, Middle, Maiden Surname) Phebe Ely			
19a. INFORMANT'S NAME (Type/Print) Rev. Isaac Jenkins				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 711 Short St. Pocomoke, Md. 21851			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) New Macedonia Bapt. Ch. 4-15-95		20c. LOCATION — City or Town, State Westover, Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Keith E. Wharton				22. NAME AND ADDRESS OF FACILITY Wharton Funeral Home-Accomac, Va. 23501			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
a. hypoxia , Possible pulmonary embolism DUE TO (OR AS A CONSEQUENCE OF):							
b. Sarcoidosis DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER M. Williams MD				29c. LICENSE NUMBER L9817		29d. DATE SIGNED (Month, Day, Year) 4/11/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) M. Williams MD 600 N. Wolfe Street Baltimore, MD 21205							
31. DATE FILED (Month, Day, Year) 4 APR 14 1995		32. REGISTRAR'S SIGNATURE Julia S. Davidson-Randall					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13779

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) HAZEL JONES				2. DATE OF DEATH MONTH DAY YEAR APRIL 09 1995		3. TIME OF DEATH 1:35 P M	
4. SOCIAL SECURITY NUMBER 212-74-9819		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 89 YRS.		7. DATE OF BIRTH (Month, Day, Year) 8/28/1905	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) Berlin Nursing Home		9b. CITY, TOWN OR LOCATION OF DEATH Berlin	
9c. COUNTY OF DEATH Worcester				10a. STATE Maryland		10b. COUNTY Worcester	
10c. CITY, TOWN OR LOCATION Pocomoke City				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 4641 Stockton Road	
10f. ZIP CODE 21851				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+) 7				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) Denard Holland				18. MOTHER'S NAME (First, Middle, Maiden Surname) Annie Ward			
19a. INFORMANT'S NAME (Type/Print) Marion S. Jones				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4641 Stockton Rd., Pocomoke City, Md. 21851			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Goodwill Cemetery 4/11		20c. LOCATION — City or Town, State Pocomoke City, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Scott S. Melson</i>				22. NAME AND ADDRESS OF FACILITY Melson Funeral Home PO Box 64, Pocomoke City, Md. 21851			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → coronary artery disease							
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
a. DUE TO (OR AS A CONSEQUENCE OF): arteriosclerosis							
b. DUE TO (OR AS A CONSEQUENCE OF): age							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. terminal pneumonia							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER D02026		29d. DATE SIGNED (Month, Day, Year) Apr 11 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) FEDERICO G. ARTHES, MD 1622A OCEAN PINES BERLIN, MD. 21811 410-641-6363							
31. DATE FILED (Month, Day, Year) APR 13 1995				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13780

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) HELEN JENKINS				2. DATE OF DEATH MONTH DAY YEAR 04 28 95		3. TIME OF DEATH 11:30 PM	
4. SOCIAL SECURITY NUMBER 225-28-5030		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 79 YRS.		7. DATE OF BIRTH (Month, Day, Year) Aug. 15, 1915	
8. BIRTHPLACE (State or Foreign Country) Virginia				9a. FACILITY NAME (If not institution, give street and number) Reeders Memorial Home		9b. CITY, TOWN OR LOCATION OF DEATH Boonsboro	
9c. COUNTY OF DEATH Washington				10a. STATE Maryland		10b. COUNTY Washington	
10c. CITY, TOWN OR LOCATION Boonsboro				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 143 S. Main St.	
10f. ZIP CODE 21713				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home	
17. FATHER'S NAME (First, Middle, Last) Richard Edwin Jolliffe				18. MOTHER'S NAME (First, Middle, Maiden Surname) Pearl Settle			
19a. INFORMANT'S NAME (Type/Print) Ray Jenkins				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 1804, Shepherdstown, WV 25443			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Hillcrest Memory Gardens 5/2/95		20c. LOCATION — City or Town, State Jefferson		20d. LOCATION — City or Town, State Jefferson	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Found & Sons Funeral Home 850 Sperryville Pike Culpeper, Va 22701			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF): Coronary Artery Disease Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Gastrointestinal Bleed DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Severe Pneumonia Possible Pneumonia							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. DESCRIBE HOW INJURY OCCURRED			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER M.D.				29c. LICENSE NUMBER D45031		29d. DATE SIGNED (Month, Day, Year) 4/29 95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MD							
31. DATE FILED (Month, Day, Year) MAY 05 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13781

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) Mary Myung S. Kim				2. DATE OF DEATH MONTH April DAY 16 YEAR 1995		3. TIME OF DEATH 2:00 PM	
4. SOCIAL SECURITY NUMBER 219-35-7252		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 43 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0	IF UNDER 24 HRS. HOURS 0 MIN. 0	7. DATE OF BIRTH (Month, Day, Year) Aug. 16, 1951	
8. BIRTHPLACE (State or Foreign Country) Korea				9. FACILITY NAME (If not institution, give street and number) 11632 Lockwood Drive, Apt. 104		10. CITY, TOWN OR LOCATION OF DEATH Silver Spring	
11. RESIDENCE OF DECEDENT				12. COUNTY OF DEATH Montgomery		13. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
14. STATE Maryland		15. COUNTY Montgomery		16. CITY, TOWN OR LOCATION Silver Spring		17. CITIZEN OF WHAT COUNTRY? Korea	
18. STREET AND NUMBER 11632 Lockwood Drive, Apt. 1104				19. ZIP CODE 20904		20. CITIZEN OF WHAT COUNTRY? Korea	
21. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		22. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		23. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		24. RACE — American Indian, Black, White, etc. Specify: Korean	
25. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College		26. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		27. KIND OF BUSINESS/INDUSTRY Own Home			
28. FATHER'S NAME (First, Middle, Last) Park Yong Jin				29. MOTHER'S NAME (First, Middle, Maiden Surname) Im Kook			
30. INFORMANT'S NAME (Type/Print) Kyung Kim				31. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20904 11632 Lockwood Drive, Apt. 1104, Silver Spring, MD			
32. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		33. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gate of Heaven Cemetery 4-19-95		34. DATE 4-19-95		35. LOCATION — City or Town, State Silver Spring, Maryland	
36. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Shirley Trent-Holland</i>				37. NAME AND ADDRESS OF FACILITY Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland 20904			
38. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Uterine Cancer DUE TO (OR AS A CONSEQUENCE OF): b. Metastatic cancer of lungs DUE TO (OR AS A CONSEQUENCE OF): c. Metastatic cancer of bone DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
39. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
40. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>				41. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		42. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
43. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		44. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
45. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		46. DATE OF INJURY (Month, Day, Year)		47. TIME OF INJURY M		48. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
49. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		50. DESCRIBE NOW INJURY OCCURRED					
51. LOCATION (Street and Number or Rural Route Number, City or Town, State)		52. DATE SIGNED (Month, Day, Year) April 17, 1995					
53. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				54. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. Year-Kwon Yoon</i>			
55. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Year-Kwon Yoon, 7307 Baltimore Ave., College Park, MD 20740				56. LICENSE NUMBER D14905			
57. DATE FILED (Month, Day, Year) APR 21 1995				58. REGISTRAR'S SIGNATURE <i>John A. ...</i>			

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13782

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) DONALD ALLEN KAYSER				2. DATE OF DEATH MONTH 04 DAY 08 YEAR 95		3. TIME OF DEATH 7:13 PM	
4. SOCIAL SECURITY NUMBER 219-54-0923		5. SEX 1 <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 45 YRS.		7. DATE OF BIRTH (Month, Day, Year) JAN 07 50	
8a. FACILITY NAME (If not institution, give street and number) WASHINGTON CO HOSPITAL				8b. CITY, TOWN OR LOCATION OF DEATH HAGERSTOWN MD		8c. COUNTY OF DEATH WASHINGTON	
RESIDENCE OF DECEDENT							
10a. STATE MD		10b. COUNTY Washington		10c. CITY, TOWN OR LOCATION Hagerstown		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 920 Linwood Road				10f. ZIP CODE 21740		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES Navy Reserves		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yee or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 0-12 College (1-4 or 5+) 0				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Sales Associate		16b. KIND OF BUSINESS/INDUSTRY Appliance	
17. FATHER'S NAME (First, Middle, Last) Rupert L. Kayser, Jr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Virginia Lee Albert			
19a. INFORMANT'S NAME (Type/Print) Linda Kayser				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1227 W. Church Street Hagerstown, Md. 21740			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Hagerstown Crematory 4-12-95		20c. LOCATION — City or Town, State Hagerstown, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Scott Minnick</i>				22. NAME AND ADDRESS OF FACILITY Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 21740			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Coronary occlusion							
Due to (or as a consequence of):							
b. Arterio sclerosis							
Due to (or as a consequence of):							
c. _____							
Due to (or as a consequence of):							
d. _____							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>H N Weeks</i>				29c. LICENSE NUMBER DN 266		29d. DATE SIGNED (Month, Day, Year) April 8 95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) H N Weeks 550 Northern Ave Hagerstown, Md							
31. DATE FILED (Month, Day, Year) APR 12 1995				32. REGISTRAR'S SIGNATURE <i>John Hudson Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13783

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) LAWRENCE E. KNIGHT, III				2. DATE OF DEATH MONTH DAY YEAR APRIL 12 1995		3. TIME OF DEATH 10:17 am M	
4. SOCIAL SECURITY NUMBER 228-24-4742		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 67 YRS.		7. DATE OF BIRTH (Month, Day, Year) JULY 3 1927	
9a. FACILITY NAME (If not institution, give street and number) ANNE ARUNDEL MEDICAL CENTER				9b. CITY, TOWN OR LOCATION OF DEATH ANNAPOLIS		9c. COUNTY OF DEATH ANNE ARUNDEL	
10a. STATE MARYLAND				10b. COUNTY ANNE ARUNDEL		10c. CITY, TOWN OR LOCATION ANNAPOLIS	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 909 COACHWAY			
10f. ZIP CODE 21401				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 6+		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) PRINCIPAL		16b. KIND OF BUSINESS/INDUSTRY A.A. CO. BOARD OF EDUCATION			
17. FATHER'S NAME (First, Middle, Last) LAURENCE E. KNIGHT				18. MOTHER'S NAME (First, Middle, Maiden Surname) OCTAVIA WEST			
19a. INFORMANT'S NAME (Type/Print) DORIS S. KNIGHT				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 909 COACHWAY ANNAPOLIS, MD. 21401			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MARYLAND VETERAN CEMETERY 4/17/95 CROWNSVILLE, MD.		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Larry H. Reese</i>				22. NAME AND ADDRESS OF FACILITY REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>ventricular fibrillation</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>Hypertension Contributing Disease</i> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death <i>1 hr</i> <i>3 hrs</i>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>R. B. Moore MD</i>				29c. LICENSE NUMBER 00056		29d. DATE SIGNED (Month, Day, Year) 4/12/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. BIERN 900 BESTGATE RD. ANNAPOLIS, MD. 21401							
31. DATE FILED (Month, Day, Year) APR 18 1995				32. REGISTRAR'S SIGNATURE <i>J. Andrew Kestell</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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95 13784

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Betty Marie White Kalvinsky				2. DATE OF DEATH MONTH April DAY 17, YEAR 1995		3. TIME OF DEATH 6:10 A.M.	
4. SOCIAL SECURITY NUMBER 216-30-0197		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 59 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) November 12, 1935	
8. BIRTHPLACE (State or Foreign Country) Elkton, MD				9. FACILITY NAME (If not institution, give street and number) Laurelwood Nursing Center		10. CITY, TOWN OR LOCATION OF DEATH Elkton	
11. COUNTY OF DEATH Cecil				12. RESIDENCE OF DECEDENT 10a. STATE Maryland 10b. COUNTY Cecil 10c. CITY, TOWN OR LOCATION North East 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13. STREET AND NUMBER 23 North Main Street	
14. ZIP CODE 21901				15. CITIZEN OF WHAT COUNTRY? USA		16. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced	
17. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				18. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		19. RACE — American Indian, Black, White, etc. Specify: White	
20. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 15				21. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Bookkeeper		22. KIND OF BUSINESS/INDUSTRY Steel Manufacturer	
23. FATHER'S NAME (First, Middle, Last) Berchell Wilmer White				24. MOTHER'S NAME (First, Middle, Maiden Surname) Edna Marie Clayton			
25. INFORMANT'S NAME (Type/Print) Sharon C. Walla				26. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 231 Little Egypt Road Elkton, MD 21921			
27. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				28. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Charlestown Cemetery 4/20		29. LOCATION — City or Town, State Charlestown, MD	
30. SIGNATURE OF FUNERAL SERVICE LICENSEE Robert T. Porek				31. NAME AND ADDRESS OF FACILITY Crouch Funeral Home 127 S. Main St. North East, MD 21901			
32. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → CVA DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <u>LOW</u> b. <u>Penicillin Allergies</u> c. <u>Paranoid schizophrenia</u> d. <u>Paranoid schizophrenia</u>							
33. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
34. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>				35. 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		36. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
37. 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		38. 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
39. 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		40. 28a. DATE OF INJURY (Month, Day, Year)		41. 28b. TIME OF INJURY M		42. 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
43. 28d. DESCRIBE HOW INJURY OCCURRED				44. 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
45. 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				46. 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
47. 29b. SIGNATURE AND TITLE OF CERTIFIER M. Lawrence				48. 29c. LICENSE NUMBER 008075		49. 29d. DATE SIGNED (Month, Day, Year) 4/15/95	
50. 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 322 E. Cecil Avenue NE MD 21901							
51. 31. DATE FILED (Month, Day, Year) APR 18 1995				52. 32. REGISTRAR'S SIGNATURE John Davidson-Karab			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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95 13785

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Mabel Estelle Keese				2. DATE OF DEATH MONTH DAY YEAR April 19, 1995		3. TIME OF DEATH 9.45 P M	
4. SOCIAL SECURITY NUMBER 218-01-4584		5. SEX 1 M 2 F		6. AGE (In yrs. last birthday) 86 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 5, 1908	
8. FACILITY NAME (If not institution, give street and number) Harford Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Havre de Grace		9c. COUNTY OF DEATH Harford	
10a. STATE Maryland				10b. COUNTY Cecil		10c. CITY, TOWN OR LOCATION Perryville	
10d. INSIDE CITY LIMITS? 1 X YES 2 NO				10e. STREET AND NUMBER 548 Aiken Avenue			
10f. ZIP CODE 21903				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 X Never Married 2 Married 3 Widowed 4 Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) Nine Years		16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY -----			
17. FATHER'S NAME (First, Middle, Last) Thomas W. Reynolds				18. MOTHER'S NAME (First, Middle, Maiden Surname) Sarah Estelle Mahan			
19a. INFORMANT'S NAME (Type/Print) Natalie A. Adams				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 725 South Washington St., Havre de Grace, MD 21078			
20a. METHOD OF DISPOSITION 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Hopewell Cemetery 4/12/95		20c. LOCATION — City or Town, State Port Deposit, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Thomas M. Patterson, Jr.				22. NAME AND ADDRESS OF FACILITY Lee A. Patterson & Son Funeral Home Perryville, Maryland 21903			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
a. Septic. DUE TO (OR AS A CONSEQUENCE OF):							
b. Chronic Pulmonary Arterial Hypertension DUE TO (OR AS A CONSEQUENCE OF):							
c. Pemphigus DUE TO (OR AS A CONSEQUENCE OF):							
d. Pneumonia							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 X Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify)					
27. MANNER OF DEATH 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 YES 2 NO	
28d. DESCRIBE NOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) Harford Memorial Hospital		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) Havre de Grace			
29a. CERTIFIER (Check only one) 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER MSUP Kim MN				29c. LICENSE NUMBER D46412		29d. DATE SIGNED (Month, Day, Year) 4/10/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 3/9 S. Wynn Ave Havre de Grace MD 21078							
31. DATE FILED (Month, Day, Year) 4/10 APR 12 1995		32. REGISTRAR'S SIGNATURE Jebia Davidson Randall					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13786

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ANNA Roberta Kelly				2. DATE OF DEATH MONTH April DAY 9 YEAR 1995		3. TIME OF DEATH 3:40 P.M.	
4. SOCIAL SECURITY NUMBER 217-22-9662		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 66 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) July 10 1928	
8. BIRTHPLACE (State or Foreign Country) Pennsylvania				9a. FACILITY NAME (If not institution, give street and number) Fallston General Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Fallston	
9c. COUNTY OF DEATH Harford				10a. STATE Maryland		10b. COUNTY Harford	
10c. CITY, TOWN OR LOCATION Edgewood				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 1205 Hanson Road	
10f. ZIP CODE 21040				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 8+) College (1-4 or 8+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Home	
17. FATHER'S NAME (First, Middle, Last) Robert Llewellyn Thompson				18. MOTHER'S NAME (First, Middle, Maiden Surname) Anna Lillian Stevens			
19a. INFORMANT'S NAME (Type/Print) Donna K. Edwards				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4300 Norrisville Road, White Hall, Md 21161			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Bel Air Memorial Gardens 4-12-95		20c. LOCATION — City or Town, State Bel Air, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Md 21009			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Acute Gastrointestinal bleed Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. Brain Stem trauma c. Seizure disorder d. Spastic paraplegia Approximate Interval Between Onset and Death Hrs Yrs Yrs Yrs							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Indwelling Foley							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER D15827		29d. DATE SIGNED (Month, Day, Year) 4/10/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) G.M. WELLS, M.D., M.P.H. 104 Plumtree Bel Air April 10, 1995							
31. DATE FILED (Month, Day, Year) APR 12 1995				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.


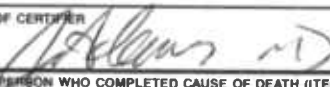
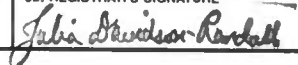
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13787

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Robert Earl LEE				2. DATE OF DEATH MONTH April 17, DAY 1995 YEAR				3. TIME OF DEATH 220 P M	
4. SOCIAL SECURITY NUMBER 216-07-4740		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 87 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7. DATE OF BIRTH (Month, Day, Year) Feb. 5, 1908				8. BIRTHPLACE (State or Foreign Country) Rhode Island					
9a. FACILITY NAME (If not institution, give street and number) Dennett Road Manor Nursing Home				9b. CITY, TOWN OR LOCATION OF DEATH Oakland				9c. COUNTY OF DEATH Garrett	
RESIDENCE OF DECEDENT									
10a. STATE MD		10b. COUNTY Garrett		10c. CITY, TOWN OR LOCATION Oakland				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 608 Mitchell Lane				10f. ZIP CODE 21550		10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Plumber		16b. KIND OF BUSINESS/INDUSTRY Plumbing Co.			
17. FATHER'S NAME (First, Middle, Last) William F. Lee				18. MOTHER'S NAME (First, Middle, Maiden Surname) Priscilla Deahl					
19a. INFORMANT'S NAME (Type/Print) Lillian M. Lee				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 608 Mitchell Lane, Oakland, MD 21550					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Garrett Co. Mem. Gardens 4/19		DATE 4/19		20c. LOCATION — City or Town, State Oakland, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Stewart Funeral Home 32 S. Second St., Oakland, MD 21550					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Congestive Heart Failure DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death Days	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D39811		29d. DATE SIGNED (Month, Day, Year) 4/19/95			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Jerry Adams, MD 311 N. Fourth St., Oakland, Maryland 21550									
31. DATE FILED (Month, Day, Year) APR 21 1995				32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13788

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) Frederick Alfred LOHR				2. DATE OF DEATH MONTH DAY YEAR April 14 1995		3. TIME OF DEATH 1:00 a m	
4. SOCIAL SECURITY NUMBER 212-12-8887		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 92 YRS.		7. DATE OF BIRTH (Month, Day, Year) Nov. 28, 1902	
8. BIRTHPLACE (State or Foreign Country) Maryland				9. FACILITY NAME (If not institution, give street and number) 225 Sky Valley Spur		10. CITY, TOWN OR LOCATION OF DEATH Swanton	
11. COUNTY OF DEATH Garrett				12. RESIDENCE OF DECEASED 10a. STATE MD		13. COUNTY Garrett	
14. CITY, TOWN OR LOCATION Swanton				15. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		16. STREET AND NUMBER 225 Sky Valley Spur	
17. ZIP CODE 21561				18. CITIZEN OF WHAT COUNTRY? USA		19. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
20. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				21. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		22. RACE — American Indian, Black, White, etc. Specify: White	
23. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) 6				24. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Laborer		25. KIND OF BUSINESS/INDUSTRY Paper Production	
26. FATHER'S NAME (First, Middle, Last) Alfred ----- Lohr				27. MOTHER'S NAME (First, Middle, Maiden Surname) Susan ----- O'Brien			
28. INFORMANT'S NAME (Type/Print) Frederick E. Lohr				29. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2020 North Glade Road, Swanton, Maryland 21561			
30. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				31. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Alexander Lohr Cem. 4/17		32. LOCATION — City or Town, State Swanton, MD	
33. SIGNATURE OF FUNERAL SERVICE LICENSEE Bradley H. Stewart				34. NAME AND ADDRESS OF FACILITY Stewart Funeral Home 32 S. Second St., Oakland, MD 21550			
35. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Ventricular Arrhythmia, Acute DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { b. Ischemic Heart Disease DUE TO (OR AS A CONSEQUENCE OF): c. Arteriosclerotic Cardio-Vascular Disease DUE TO (OR AS A CONSEQUENCE OF): d. Approximate interval Between Onset and Death Sudden Sev. Yrs. 20 years							
36. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
37. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				38. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		39. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
40. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				41. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
42. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				43. DATE OF INJURY (Month, Day, Year) 28a. TIME OF INJURY 28b. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		44. DESCRIBE HOW INJURY OCCURRED	
45. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				46. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
47. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
48. SIGNATURE AND TITLE OF CERTIFIER Herbert H. Leighton, M.D.				49. LICENSE NUMBER D 05658		50. DATE SIGNED (Month, Day, Year) April 15, 1995	
51. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Herbert H. Leighton, M.D., 502 E. Oak Street, Oakland, Maryland 21550							
52. DATE FILED (Month, Day, Year) APR 19 1995				53. REGISTRAR'S SIGNATURE John Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13789

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) S. Stratton Lange				2. DATE OF DEATH MONTH April DAY 15 YEAR 1995		3. TIME OF DEATH 8:04 P M	
4. SOCIAL SECURITY NUMBER 577-07-1098		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 85 YRS.		7. DATE OF BIRTH (Month, Day, Year) Jan. 23, 1910	
9a. FACILITY NAME (If not institution, give street and number) Holy Cross Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring		9c. COUNTY OF DEATH Montgomery	
10a. STATE MD		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Chevy Chase		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 4722 Merivale Road				10f. ZIP CODE 20815		10g. CITIZEN OF WHAT COUNTRY? U. S. A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Purchasing Agent		15b. KIND OF BUSINESS/INDUSTRY Stationary Company			
17. FATHER'S NAME (First, Middle, Last) Oscar G. Lange, Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Elizabeth Endres			
19a. INFORMANT'S NAME (Type/Print) Salda M. Lange				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4722 Merivale Rd. Chevy Chase, MD 20815			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Mount Comfort Crematory		DATE 4/19		20c. LOCATION — City or Town, State Alexandria, VA	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Deak M. Peters</i>				22. NAME AND ADDRESS OF FACILITY Joseph Gawler's Sons 5130 WI Ave. NW Washington, D.C. 20016			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sepsis Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. Alzheimer's disease b. Coronary artery disease c. d. 							Approximate interval between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Gita C. Bakshi, M.D.</i>				29c. LICENSE NUMBER D23170		29d. DATE SIGNED (Month, Day, Year) April 17, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Gita C. Bakshi, M.D. 9406 Old Georgetown Rd. Bethesda, Md. 20814							
31. DATE FILED (Month, Day, Year) APR 18 1995				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13790

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Bernard Roger Loiselle				2. DATE OF DEATH MONTH April DAY 14 YEAR 1995		3. TIME OF DEATH 1:55 P.M.	
4. SOCIAL SECURITY NUMBER 577-22-5057		5. SEX 1 <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 75 YRS.		7. DATE OF BIRTH (Month, Day, Year) May 16, 1919	
8. BIRTHPLACE (State or Foreign Country) Massachusetts				9a. FACILITY NAME (If not institution, give street and number) Shady Grove Adventist Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Rockville	
9c. COUNTY OF DEATH Montgomery				10a. STATE Maryland		10b. COUNTY Montgomery	
10c. CITY, TOWN OR LOCATION Gaithersburg				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 17060 Kings James Way	
10f. ZIP CODE 20877				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1940-1945				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: White				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) 4			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Artist				16b. KIND OF BUSINESS/INDUSTRY Art			
17. FATHER'S NAME (First, Middle, Last) Damose Peter Loiselle				18. MOTHER'S NAME (First, Middle, Maiden Surname) Rose Delima Unknown			
19a. INFORMANT'S NAME (Type/Print) Lisa Y. Hood				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5450 Watts Road, Conway, South Carolina 29526			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gate of Heaven Cemetery 4/19/95			
20c. LOCATION — City or Town, State Silver Spring, Maryland				21. SIGNATURE OF FUNERAL SERVICE LICENSEE Robert E. Ramsey			
22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd. W. Sil. Spr. MD 20901				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. VENTRICULAR FIBRILLATION DUE TO (OR AS A CONSEQUENCE OF): b. ISCHEMIC CARDIOMYOPATHY DUE TO (OR AS A CONSEQUENCE OF): c. HYPERTENSIVE CARDIOVASCULAR DISEASE DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death 30 MINUTES 10 YEARS 30 YEARS			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY M 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 28d. DESCRIBE HOW INJURY OCCURRED 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER MD			
29c. LICENSE NUMBER DIGIM				29d. DATE SIGNED (Month, Day, Year) APRIL 14 1995			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) GREGORIO KOS 15225 SHAW GLOBE RD ROCKVILLE MD 20850				31. DATE FILED (Month, Day, Year) APR 18 1995			
32. REGISTRAR'S SIGNATURE John Davidson Randall							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.


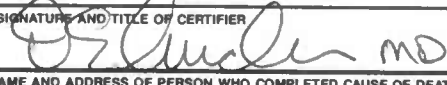

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13791

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Charles Lawrence Langenstein				2. DATE OF DEATH MONTH April DAY 17 YEAR 1995		3. TIME OF DEATH 0805 M	
4. SOCIAL SECURITY NUMBER 705-10-4931		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 82 YRS.		7. DATE OF BIRTH (Month, Day, Year) Oct. 29, 1912	
8. FACILITY NAME (If not institution, give street and number) Washington County Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Hagerstown		9c. COUNTY OF DEATH Washington	
10a. STATE Maryland				10b. COUNTY Washington		10c. CITY, TOWN OR LOCATION Hagerstown	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 309 Ridge Avenue			
10f. ZIP CODE 21740				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) 0		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) pipe fitter		16b. KIND OF BUSINESS/INDUSTRY railroad			
17. FATHER'S NAME (First, Middle, Last) Charles William Langenstein, Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Anna B. Colk			
19a. INFORMANT'S NAME (Type/Print) Hazel L. Langenstein				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 309 Ridge Ave., Hagerstown, Md. 21740			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Rose Hill Cemetery 4-20-95		20c. LOCATION — City or Town, State Hagerstown, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Aspiration Pneumonia DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Adenocarcinoma of the Prostate							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER  D.E. Anderson MD				29c. LICENSE NUMBER 042915		29d. DATE SIGNED (Month, Day, Year) 4-17-95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) D.E. Anderson, 1110 Medical Campus Rd Hagerstown Md 21742							
DATE FILED APR 18 1995 Day, Year				REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13792

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Jean B. Long				2. DATE OF DEATH MONTH DAY YEAR April 14, 1995		3. TIME OF DEATH 7:15 P.M.	
4. SOCIAL SECURITY NUMBER 549-34-3373		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 66 YRS.		7. DATE OF BIRTH (Month, Day, Year) Sept. 16, 1928	
9a. FACILITY NAME (If not institution, give street and number) 404 Park Place				9b. CITY, TOWN OR LOCATION OF DEATH Elkton		9c. COUNTY OF DEATH Cecil	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Cecil		10c. CITY, TOWN OR LOCATION Elkton		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 404 Park Place				10f. ZIP CODE 21921		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) Jason Brooks Beall				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Lovena Bishop			
19a. INFORMANT'S NAME (Type/Print) Dan L. Long				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 404 Park Place - Elkton, MD 21921			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gilpin Manor Memorial Park		DATE 4-19-1995		20c. LOCATION — City or Town, State Elkton, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Daniel S. Hicks</i>				22. NAME AND ADDRESS OF FACILITY Hicks Home for Funerals, P.A. 103 West Stockton Street Elkton, MD 21921-5521			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <i>CNS METASTASES</i>					
		b. <i>INVASIVE DUCTAL CARCINOMA BREAST</i>					
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		c. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Robert C. Gray M.D.</i>				29c. LICENSE NUMBER D01858		29d. DATE SIGNED (Month, Day, Year) 4/18/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ROBERT C. GRAY 111 RAILROAD AVE ELKTON MD							
31. DATE FILED (Month, Day, Year) APR 18 1995		32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020



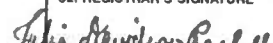
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) LOUIS J osephLAMANNA				2. DATE OF DEATH MONTH DAY YEAR APRIL 11, 1995				3. TIME OF DEATH 2:15 PM M							
4. SOCIAL SECURITY NUMBER 222-10-0742				5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 90 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) JULY 29, 1904		8. BIRTHPLACE (State or Foreign Country) Wilmington Delaware	
9a. FACILITY NAME (If not institution, give street and number) LAURELWOOD NURSING CENTER								9b. CITY, TOWN OR LOCATION OF DEATH ELKTON, MARYLAND				9c. COUNTY OF DEATH CECIL			
RESIDENCE OF DECEDENT															
10a. STATE Maryland				10b. COUNTY Cecil				10c. CITY, TOWN OR LOCATION Elkton				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STREET AND NUMBER 100 Laurel Drive								10f. ZIP CODE 21921				10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) _____				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Pharmaceutical Assistant				16b. KIND OF BUSINESS/INDUSTRY Pharmaceutical Sales							
17. FATHER'S NAME (First, Middle, Last) Angelo La Manna								18. MOTHER'S NAME (First, Middle, Maiden Surname) Grace Christiana							
19a. INFORMANT'S NAME (Type/Print) Margaret Ciconte								19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 616 New York Ave. Claymont, Delaware 19703							
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) _____				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Silverbrook Crematory 4-12-1995				20c. LOCATION — City or Town, State Wilmington, Delaware							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE  Charles Francis Mealey								22. NAME AND ADDRESS OF FACILITY Mealey Funeral Homes 703 North Broom Street Wilmington, DE							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CAD DUE TO (OR AS A CONSEQUENCE OF): b. TERMINAL ILLNESS DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Approximate Interval Between Onset and Death															
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____															
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO															
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO															
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>															
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____											
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
29b. SIGNATURE AND TITLE OF CERTIFIER 								29c. LICENSE NUMBER D32395				29d. DATE SIGNED (Month, Day, Year) APRIL 12, 1995			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Thomas Finucan 3 Mauldin Avenue Northeast Maryland 21901															
31. DATE FILED (Month, Day, Year) APR 13 1995				32. REGISTRAR'S SIGNATURE 											

95-2219-023

blh

ITEMS: 23 PART I, 27, 28a-f PER MEO FILM G-723 5/19/95 t.t
23 part II


95 13794

FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) Allen Henry Mayle				2. DATE OF DEATH MONTH DAY YEAR April 15 1995		3. TIME OF DEATH 1600	
4. SOCIAL SECURITY NUMBER UNKNOWN		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 41 YRS. IF UNDER 1 YEAR: MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.: MONTHS DAYS HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) May 4, 1953	
9a. FACILITY NAME (If not institution, give street and number) in creek- Route 495-(Swanton Road)				9b. CITY, TOWN OR LOCATION OF DEATH Swanton		9c. COUNTY OF DEATH Garrett	
10a. STATE MD		10b. COUNTY Garrett		10c. CITY, TOWN OR LOCATION Swanton		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER P.O. Box 1314				10f. ZIP CODE 21561		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+) College		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Mechanic		15b. KIND OF BUSINESS/INDUSTRY Auto Repair			
17. FATHER'S NAME (First, Middle, Last) Floyd Henry Mayle				18. MOTHER'S NAME (First, Middle, Maiden Surname) Gloria ----- Hayes			
19a. INFORMANT'S NAME (Type/Print) Beulah Mayle				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1695 Upperman Road, Oakland, Maryland 21550			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Deer Park Cemetery 4/19		20c. LOCATION — City or Town, State Deer Park, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Stewart Funeral Home 32 S. Second St., Oakland, MD 21550			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → HEAD INJURIES COMPLICATED BY DROWNING DUE TO (OR AS A CONSEQUENCE OF): a. _____ b. _____ c. _____ d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST e. _____ f. _____ g. _____ h. _____ i. _____ j. _____ k. _____ l. _____ m. _____ n. _____ o. _____ p. _____ q. _____ r. _____ s. _____ t. _____ u. _____ v. _____ w. _____ x. _____ y. _____ z. _____ aa. _____ ab. _____ ac. _____ ad. _____ ae. _____ af. _____ ag. _____ ah. _____ ai. _____ aj. _____ ak. _____ al. _____ am. _____ an. _____ ao. _____ ap. _____ aq. _____ ar. _____ as. _____ at. _____ au. _____ av. _____ aw. _____ ax. _____ ay. _____ az. _____ ba. _____ bb. _____ bc. _____ bd. _____ be. _____ bf. _____ bg. _____ bh. _____ bi. _____ bj. _____ bk. _____ bl. _____ bm. _____ bn. _____ bo. _____ bp. _____ bq. _____ br. _____ bs. _____ bt. _____ bu. _____ bv. _____ bw. _____ bx. _____ by. _____ bz. _____ ca. _____ cb. _____ cc. _____ cd. _____ ce. _____ cf. _____ cg. _____ ch. _____ ci. _____ cj. _____ ck. _____ cl. _____ cm. _____ cn. _____ co. _____ cp. _____ cq. _____ cr. _____ cs. _____ ct. _____ cu. _____ cv. _____ cw. _____ cx. _____ cy. _____ cz. _____ da. _____ db. _____ dc. _____ dd. _____ de. _____ df. _____ dg. _____ dh. _____ di. _____ dj. _____ dk. _____ dl. _____ dm. _____ dn. _____ do. _____ dp. _____ dq. _____ dr. _____ ds. _____ dt. _____ du. _____ dv. _____ dw. _____ dx. _____ dy. _____ dz. _____ ea. _____ eb. _____ ec. _____ ed. _____ ee. _____ ef. _____ eg. _____ eh. _____ ei. _____ ej. _____ ek. _____ el. _____ em. _____ en. _____ eo. _____ ep. _____ eq. _____ er. _____ es. _____ et. _____ eu. _____ ev. _____ ew. _____ ex. _____ ey. _____ ez. _____ fa. _____ fb. _____ fc. _____ fd. _____ fe. _____ ff. _____ fg. _____ fh. _____ fi. _____ fj. _____ fk. _____ fl. _____ fm. _____ fn. _____ fo. _____ fp. _____ fq. _____ fr. _____ fs. _____ ft. _____ fu. _____ fv. _____ fw. _____ fx. _____ fy. _____ fz. _____ ga. _____ gb. _____ gc. _____ gd. _____ ge. _____ gf. _____ gg. _____ gh. _____ gi. _____ gj. _____ gk. _____ gl. _____ gm. _____ gn. _____ go. _____ gp. _____ gq. _____ gr. _____ gs. _____ gt. _____ gu. _____ gv. _____ gw. _____ gx. _____ gy. _____ gz. _____ ha. _____ hb. _____ hc. _____ hd. _____ he. _____ hf. _____ hg. _____ hh. _____ hi. _____ hj. _____ hk. _____ hl. _____ hm. _____ hn. _____ ho. _____ hp. _____ hq. _____ hr. _____ hs. _____ ht. _____ hu. _____ hv. _____ hw. _____ hx. _____ hy. _____ hz. _____ ia. _____ ib. _____ ic. _____ id. _____ ie. _____ if. _____ ig. _____ ih. _____ ii. _____ ij. _____ ik. _____ il. _____ im. _____ in. _____ io. _____ ip. _____ iq. _____ ir. _____ is. _____ it. _____ iu. _____ iv. _____ iw. _____ ix. _____ iy. _____ iz. _____ ja. _____ jb. _____ jc. _____ jd. _____ je. _____ jf. _____ jg. _____ jh. _____ ji. _____ jj. _____ jk. _____ jl. _____ jm. _____ jn. _____ jo. _____ jp. _____ jq. _____ jr. _____ js. _____ jt. _____ ju. _____ jv. _____ jw. _____ jx. _____ jy. _____ jz. _____ ka. _____ kb. _____ kc. _____ kd. _____ ke. _____ kf. _____ kg. _____ kh. _____ ki. _____ kj. _____ kl. _____ km. _____ kn. _____ ko. _____ kp. _____ kq. _____ kr. _____ ks. _____ kt. _____ ku. _____ kv. _____ kw. _____ kx. _____ ky. _____ kz. _____ la. _____ lb. _____ lc. _____ ld. _____ le. _____ lf. _____ lg. _____ lh. _____ li. _____ lj. _____ lk. _____ ll. _____ lm. _____ ln. _____ lo. _____ lp. _____ lq. _____ lr. _____ ls. _____ lt. _____ lu. _____ lv. _____ lw. _____ lx. _____ ly. _____ lz. _____ ma. _____ mb. _____ mc. _____ md. _____ me. _____ mf. _____ mg. _____ mh. _____ mi. _____ mj. _____ mk. _____ ml. _____ mm. _____ mn. _____ mo. _____ mp. _____ mq. _____ mr. _____ ms. _____ mt. _____ mu. _____ mv. _____ mw. _____ mx. _____ my. _____ mz. _____ na. _____ nb. _____ nc. _____ nd. _____ ne. _____ nf. _____ ng. _____ nh. _____ ni. _____ nj. _____ nk. _____ nl. _____ nm. _____ nn. _____ no. _____ np. _____ nq. _____ nr. _____ ns. _____ nt. _____ nu. _____ nv. _____ nw. _____ nx. _____ ny. _____ nz. _____ oa. _____ ob. _____ oc. _____ od. _____ oe. _____ of. _____ og. _____ oh. _____ oi. _____ oj. _____ ok. _____ ol. _____ om. _____ on. _____ oo. _____ op. _____ oq. _____ or. _____ os. _____ ot. _____ ou. _____ ov. _____ ow. _____ ox. _____ oy. _____ oz. _____ pa. _____ pb. _____ pc. _____ pd. _____ pe. _____ pf. _____ pg. _____ ph. _____ pi. _____ pj. _____ pk. _____ pl. _____ pm. _____ pn. _____ po. _____ pp. _____ pq. _____ pr. _____ ps. _____ pt. _____ pu. _____ pv. _____ pw. _____ px. _____ py. _____ pz. _____ qa. _____ qb. _____ qc. _____ qd. _____ qe. _____ qf. _____ qg. _____ qh. _____ qi. _____ qj. _____ qk. _____ ql. _____ qm. _____ qn. _____ qo. _____ qp. _____ qq. _____ qr. _____ qs. _____ qt. _____ qu. _____ qv. _____ qw. _____ qx. _____ qy. _____ qz. _____ ra. _____ rb. _____ rc. _____ rd. _____ re. _____ rf. _____ rg. _____ rh. _____ ri. _____ rj. _____ rk. _____ rl. _____ rm. _____ rn. _____ ro. _____ rp. _____ rq. _____ rr. _____ rs. _____ rt. _____ ru. _____ rv. _____ rw. _____ rx. _____ ry. _____ rz. _____ sa. _____ sb. _____ sc. _____ sd. _____ se. _____ sf. _____ sg. _____ sh. _____ si. _____ sj. _____ sk. _____ sl. _____ sm. _____ sn. _____ so. _____ sp. _____ sq. _____ sr. _____ ss. _____ st. _____ su. _____ sv. _____ sw. _____ sx. _____ sy. _____ sz. _____ ta. _____ tb. _____ tc. _____ td. _____ te. _____ tf. _____ tg. _____ th. _____ ti. _____ tj. _____ tk. _____ tl. _____ tm. _____ tn. _____ to. _____ tp. _____ tq. _____ tr. _____ ts. _____ tt. _____ tu. _____ tv. _____ tw. _____ tx. _____ ty. _____ tz. _____ ua. _____ ub. _____ uc. _____ ud. _____ ue. _____ uf. _____ ug. _____ uh. _____ ui. _____ uj. _____ uk. _____ ul. _____ um. _____ un. _____ uo. _____ up. _____ uq. _____ ur. _____ us. _____ ut. _____ uu. _____ uv. _____ uw. _____ ux. _____ uy. _____ uz. _____ va. _____ vb. _____ vc. _____ vd. _____ ve. _____ vf. _____ vg. _____ vh. _____ vi. _____ vj. _____ vk. _____ vl. _____ vm. _____ vn. _____ vo. _____ vp. _____ vq. _____ vr. _____ vs. _____ vt. _____ vu. _____ vv. _____ vw. _____ vx. _____ vy. _____ vz. _____ wa. _____ wb. _____ wc. _____ wd. _____ we. _____ wf. _____ wg. _____ wh. _____ wi. _____ wj. _____ wk. _____ wl. _____ wm. _____ wn. _____ wo. _____ wp. _____ wq. _____ wr. _____ ws. _____ wt. _____ wu. _____ wv. _____ ww. _____ wx. _____ wy. _____ wz. _____ xa. _____ xb. _____ xc. _____ xd. _____ xe. _____ xf. _____ xg. _____ xh. _____ xi. _____ xj. _____ xk. _____ xl. _____ xm. _____ xn. _____ xo. _____ xp. _____ xq. _____ xr. _____ xs. _____ xt. _____ xu. _____ xv. _____ xw. _____ xx. _____ xy. _____ xz. _____ ya. _____ yb. _____ yc. _____ yd. _____ ye. _____ yf. _____ yg. _____ yh. _____ yi. _____ yj. _____ yk. _____ yl. _____ ym. _____ yn. _____ yo. _____ yp. _____ yq. _____ yr. _____ ys. _____ yt. _____ yu. _____ yv. _____ yw. _____ yx. _____ yy. _____ yz. _____ za. _____ zb. _____ zc. _____ zd. _____ ze. _____ zf. _____ zg. _____ zh. _____ zi. _____ zj. _____ zk. _____ zl. _____ zm. _____ zn. _____ zo. _____ zp. _____ zq. _____ zr. _____ zs. _____ zt. _____ zu. _____ zv. _____ zw. _____ zx. _____ zy. _____ zz. _____							

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

FATTY LIVER DUE TO CHRONIC ALCOHOLISM**DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐**25. WAS CASE REFERRED TO MEDICAL EXAMINER?
☒ YES ☐ NO

26. PLACE OF DEATH (Check only one)

HOSPITAL:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

OTHER:

☐ Nursing Home ☐ Residence ☒ Other (Specify)**at scene**

27. MANNER OF DEATH

☐ Natural☒ Accident☐ Suicide☐ Homicide☒ Pending Investigation☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

FOUND: 4/15/95

28b. TIME OF INJURY

3:05 P M

28c. INJURY AT WORK?

☐ YES ☒ NO

28d. DESCRIBE HOW INJURY OCCURRED

SUBJECT FELL & DROWNED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

STREAM28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
**RT. 495 (SWANTON ROAD)
SWANTON, MD.**

29a. CERTIFIER (Check only one)

☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER



29c. LICENSE NUMBER

O.C.M.E.

29d. DATE SIGNED (Month, Day, Year)

April 16 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

MALAPASON N. KOREW III Penn Street, Baltimore, Maryland 21201

31. DATE FILED (Month, Day, Year)

APR 19 1995

32. REGISTRAR'S SIGNATURE



DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.


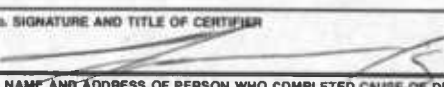
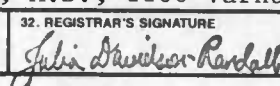
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE											
CERTIFICATE OF DEATH											
REG. NO.											
1. DECEASED'S NAME (First, Middle, Last) <i>Edward Murray Metz</i>				2. DATE OF DEATH MONTH DAY YEAR <i>April 15 1995</i>		3. TIME OF DEATH <i>1:04 PM</i>					
4. SOCIAL SECURITY NUMBER <i>217 28 7837</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <i>63</i> YRS.	7. DATE OF BIRTH (Month, Day, Year) <i>Dec. 14, 1931</i>		8. BIRTHPLACE (State or Foreign Country) <i>Maryland</i>					
9a. FACILITY NAME (If not institution, give street and number) <i>Shady Grove Adventist Hospital</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Rockville</i>		9c. COUNTY OF DEATH <i>Montgomery</i>					
10a. STATE <i>Maryland</i>		10b. COUNTY <i>Montgomery</i>		10c. CITY, TOWN OR LOCATION <i>Germantown</i>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
10e. STREET AND NUMBER <i>18825 Darnestown-Germantown Road</i>				10f. ZIP CODE <i>20874</i>		10g. CITIZEN OF WHAT COUNTRY? <i>United States</i>					
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR OATES <i>Korea</i>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>					
15. DECEASED'S EDUCATION (Specify only highest grade completed) <i>Elementary/Secondary (0-12) 10</i>		15a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Truck Driver</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Burial Vault Company</i>							
17. FATHER'S NAME (First, Middle, Last) <i>William Frederick Metz, Sr.</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Mary Jane Perrell</i>							
19a. INFORMANT'S NAME (Type/Print) <i>Mary Ann Duvall</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>12519 Crossridge Way, Germantown, Maryland 20874</i>							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Specify cemetery, crematory or other place) <i>Baptist Church Cemetery Germantown April 19, 1995</i>		20c. LOCATION — City or Town, State <i>Germantown, Maryland</i>							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> M00689				22. NAME AND ADDRESS OF FACILITY <i>Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805</i>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>arteriosclerotic heart disease</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { b. _____ c. _____ d. _____ DUE TO (OR AS A CONSEQUENCE OF):								Approximate Interval Between Onset and Death <i>years</i>			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>End Stage Renal Disease</i>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <i>D08546</i>		29d. DATE SIGNED (Month, Day, Year) <i>April 15-95</i>					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>John Tumber 8218 Wisconsin Ave Bethesda</i>											
31. DATE FILED (Month, Day, Year) <i>APR 19 1995</i>		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>									

95 13796

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Ronald Kenneth Mundy				2. DATE OF DEATH MONTH DAY YEAR April 14, 1995				3. TIME OF DEATH 7:04 A M							
4. SOCIAL SECURITY NUMBER 280-28-3531		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 64 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) Jan. 1, 1931		8. BIRTHPLACE (State or Foreign Country) Ohio			
9a. FACILITY NAME (If not institution, give street and number) Holy Cross Hospital						9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring				9c. COUNTY OF DEATH Montgomery					
10a. STATE Maryland				10b. COUNTY Montgomery				10c. CITY, TOWN OR LOCATION Kensington				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER 9541 East Bexhill Road						10f. ZIP CODE 20895				10g. CITIZEN OF WHAT COUNTRY? United States					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: Black					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Attorney				16b. KIND OF BUSINESS/INDUSTRY Legal							
17. FATHER'S NAME (First, Middle, Last) Herbert P. Mundy						18. MOTHER'S NAME (First, Middle, Maiden Surname) Mattie Robinson									
19a. INFORMANT'S NAME (Type/Print) Mignon Mundy						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9541 E. Bexhill Road, Kensington, Md. 20895									
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Parklawn Mem. Park 4/19/95				20c. LOCATION — City or Town, State Rockville, Maryland							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 						22. NAME AND ADDRESS OF FACILITY McGuire Funeral Service, Inc. 7400 Georgia Ave. N.W., Washington, D.C.									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death			
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiopulmonary Arrest DUE TO (OR AS A CONSEQUENCE OF):												Immediate			
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. Hypertension DUE TO (OR AS A CONSEQUENCE OF):												More than 5 years			
c. _____ DUE TO (OR AS A CONSEQUENCE OF):															
d. _____ DUE TO (OR AS A CONSEQUENCE OF):															
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
29b. SIGNATURE AND TITLE OF CERTIFIER 						29c. LICENSE NUMBER D34445				29d. DATE SIGNED (Month, Day, Year) April 18, 1995					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Francisco C. King, M.D., 1160 Varnum St. N.E., Washington, D.C. 20017															
31. DATE FILED (Month, Day, Year) APR 19 1995				32. REGISTRAR'S SIGNATURE 											

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 13797

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Mabel H. Marshall				2. DATE OF DEATH MONTH DAY YEAR April 14, 1995		3. TIME OF DEATH 2:00 P M	
4. SOCIAL SECURITY NUMBER 224-62-5905		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 99 YRS.	7. DATE OF BIRTH (Month, Day, Year) Dec. 18, 1895		8. BIRTHPLACE (State or Foreign Country) Pennsylvania	
9a. FACILITY NAME (If not institution, give street and number) Med Bridge Medical & Physical Rehabilitation Center				9b. CITY, TOWN OR LOCATION OF DEATH Wheaton		9c. COUNTY OF DEATH Montgomery	
10a. STATE Maryland				10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Chevy Chase	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NO NUMBER 3805 Williams Lane		10f. ZIP CODE 20815	
10g. CITIZEN OF WHAT COUNTRY? United States				11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES World War I	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+) 12	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker				16b. KIND OF BUSINESS/INDUSTRY Own Home		17. FATHER'S NAME (First, Middle, Last) Washington E. Hilsee	
18. MOTHER'S NAME (First, Middle, Maiden Surname) Annie Lutner				19a. INFORMANT'S NAME (Type/Print) Edward L. Marshall, Jr.		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3805 Williams Lane, Chevy Chase, Maryland 20815	
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Arlington National Cemetery April 25, 1995		20c. LOCATION — City or Town, State Arlington, Virginia	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Barbara J. McMullen Lawrence</i> M00831				22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Cardiopulmonary Arrest</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>Respiratory Failure</u> DUE TO (OR AS A CONSEQUENCE OF): c. <u>Dehydration</u> DUE TO (OR AS A CONSEQUENCE OF): d. <u>Malnutrition</u> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Dementia, Cerebrovascular Accident</u>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH X <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. DESCRIBE HOW INJURY OCCURRED			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER D32332		29d. DATE SIGNED (Month, Day, Year) April 14, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Suresh Kumar Gupta, M.D. 9801 Georgia Avenue, Silver Spring, Maryland 20902							
31. DATE FILED (Month, Day, Year) APR 19 1995				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ROSAURA MARRERO-RIVERA				2. DATE OF DEATH MONTH APRIL DAY 12 YEAR 1995		3. TIME OF DEATH 2:55 A M	
4. SOCIAL SECURITY NUMBER 058-24-6865		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 85 YRS.		7. DATE OF BIRTH (Month, Day, Year) Feb 28, 1910	
8. BIRTHPLACE (State or Foreign Country) Puerto Rico				9a. FACILITY NAME (If not institution, give street and number) Washington Adventist Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Takoma Park	
9c. COUNTY OF DEATH Montgomery				10a. STATE Maryland		10b. COUNTY Prince George's	
10c. CITY, TOWN OR LOCATION Takoma Park				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 7201 Flower Avenue	
10f. ZIP CODE 20912				10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify: Puerto Rican		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) 		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Tailor / Seamstress		16b. KIND OF BUSINESS/INDUSTRY Clothing / Alterations			
17. FATHER'S NAME (First, Middle, Last) Octaviano Marrero				18. MOTHER'S NAME (First, Middle, Maiden Surname) Carmela Rosario			
19a. INFORMANT'S NAME (Type/Print) Benjamin Rivera, Sr. (Son)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 813 Forston Street, Takoma Park, MD 20912			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gate of Heaven Cemetery		DATE 4-17		20c. LOCATION — City or Town, State Silver Spring, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE M00827				22. NAME AND ADDRESS OF FACILITY Rapp Funeral Services, P.A. 933 Gist Ave, Silver Spring, MD 20910			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Smoke inhalation and thermal injuries DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO (Partial)
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 4-12-95		28b. TIME OF INJURY 2:10 A M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED Victim of House fire		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) Residence		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 7201 Flower Ave, Takoma Park, MD			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER David R. Fowler, M.D.				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) April 14, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) David R. Fowler, M.D. 111 Penn Street, Baltimore, Maryland 21201							
31. DATE FILED (Month, Day, Year) APR 18 1995				32. REGISTRAR'S SIGNATURE John Davidson Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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95 13799

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) RICHARD WAYNE MERSON Sr				2. DATE OF DEATH MONTH DAY YEAR April 14 95		3. TIME OF DEATH 1:25 PM	
4. SOCIAL SECURITY NUMBER 215-52-7171		5. SEX 1 M 2 F		6. AGE (In yrs. last birthday) 46 YRS.		7. DATE OF BIRTH (Month, Day, Year) Nov. 1, 1948	
8. BIRTHPLACE (State or Foreign Country) Washington, DC		9a. FACILITY NAME (If not institution, give street and number) Montgomery General Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Olney		9c. COUNTY OF DEATH Montgomery	
10a. STATE Maryland				10b. COUNTY Prince Georges		10c. CITY, TOWN OR LOCATION Hyattsville	
10d. INSIDE CITY LIMITS? 1 YES 2 NO				10e. STREET AND NUMBER 2010 Rittenhouse Street			
10f. ZIP CODE 20782				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) 9		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Painter		15b. KIND OF BUSINESS/INDUSTRY Painting			
17. FATHER'S NAME (First, Middle, Last) Carroll Merson				16. MOTHER'S NAME (First, Middle, Maiden Surname) Phoebe Davis			
19a. INFORMANT'S NAME (Type/Print) Richard W. Merson, Jr.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18503 Owl Run Way, Germantown, MD 20874			
20a. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Burtonsville Union Cemetery 4/18/95		20c. LOCATION — City or Town, State Burtonsville, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Robert E. Ramsey				22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc 500 University Blvd. W. Sil. Spr. MD 20901			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. arteriosclerotic Heart Disease IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death 1 hr.							PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? YES 2 NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify)					
27. MANNER OF DEATH 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 YES 2 NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER John T. Taylor				29c. LICENSE NUMBER 208546		29d. DATE SIGNED (Month, Day, Year) April 14 95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John T. Taylor 8218 Wisconsin Ave							
31. DATE FILED (Month, Day, Year) APR 18 1995				32. REGISTRAR'S SIGNATURE John Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

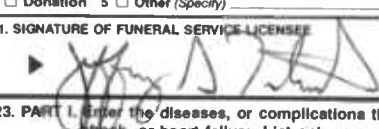
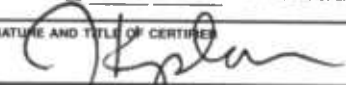

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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95 13800

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Edward Manouelian				2. DATE OF DEATH MONTH DAY YEAR April 13, 1995		3. TIME OF DEATH 6:45P M	
4. SOCIAL SECURITY NUMBER 577 32 7554		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 67 YRS.		7. DATE OF BIRTH (Month, Day, Year) Feb. 12, 1928	
8. BIRTHPLACE (State or Foreign Country) Rhode Island				9a. FACILITY NAME (If not institution, give street and number) 2 Duke Court		9b. CITY, TOWN OR LOCATION OF DEATH Rockville	
9c. COUNTY OF DEATH Montgomery				10a. STATE Maryland		10b. COUNTY Montgomery	
10c. CITY, TOWN OR LOCATION Rockville				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 2 Duke Court	
10f. ZIP CODE 20850				10g. CITIZEN OF WHAT COUNTRY? United States		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES Korea				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) - College (14 or 5+) 4				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Store Manager		16b. KIND OF BUSINESS/INDUSTRY Retail Sales	
17. FATHER'S NAME (First, Middle, Last) Vartan Manouelian				18. MOTHER'S NAME (First, Middle, Maiden Surname) Anoush Bogosian			
19a. INFORMANT'S NAME (Type/Print) Lora T. Manouelian				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Duke Court, Rockville, Maryland 20850			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Montgomery Crematorium, Inc. April 15, 1995		20c. LOCATION — City or Town, State Bethesda, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE  M00689				22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, MD 20814-3501			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Bladder Cancer DUE TO (OR AS A CONSEQUENCE OF): b. Bone Metastases DUE TO (OR AS A CONSEQUENCE OF): c. Metastases to penis DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death 1 1/2 years
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)	
28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER D35635		29d. DATE SIGNED (Month, Day, Year) April 14, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Joseph Kaplan, M.D. 9715 Medical Center Drive, Rockville, Maryland 20850							
31. DATE FILED (Month, Day, Year) APR 17 1995		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13801

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Katherine Irene Pearce Merrey				2. DATE OF DEATH MONTH 4 DAY 21 YEAR 95		3. TIME OF DEATH 1545 M	
4. SOCIAL SECURITY NUMBER 213-05-6123		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 83 YRS.	7. DATE OF BIRTH (Month, Day, Year) 4-27-11		8. BIRTHPLACE (State or Foreign Country) Pa.	
9a. FACILITY NAME (If not institution, give street and number) Medpointe				9b. CITY, TOWN OR LOCATION OF DEATH Elkton		9c. COUNTY OF DEATH Cecil	
RESIDENCE OF DECEDENT							
10a. STATE Md.		10b. COUNTY Cecil		10c. CITY, TOWN OR LOCATION Elkton		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 109 Locust Lane				10f. ZIP CODE 21921		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 8+) 1		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Secretary		16b. KIND OF BUSINESS/INDUSTRY Legal			
17. FATHER'S NAME (First, Middle, Last) Ralph Watts Pearce				18. MOTHER'S NAME (First, Middle, Maiden Surname) Nellie Porter Reed			
19a. INFORMANT'S NAME (Type/Print) Kaye Irene Merrey				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 109 Locust Lane, Elkton, Md. 21921			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Rosebank Cemetery 4/25/95		20c. LOCATION — City or Town, State Rising Sun, Md.		20d. DATE 4/25/95	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY Gee Funeral Home 259 E. Main St., Elkton, Md. 21921			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Ca of cervix with metastases							
b. ASVD							
c. Diabetic melita							
d. Hypertension							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Jui Chih Hsu MD				29c. LICENSE NUMBER D04823		29d. DATE SIGNED (Month, Day, Year) 4/22/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Jui Chih Hsu, MD 223 West main st. Elkton, Md 21921							
31. DATE FILED (Month, Day, Year) APR 25 1995				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

SECTION FIVE

SECTION FIVE

RESEARCH BOND

RESEARCH BOND

RESEARCH BOND

95 13802

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Odeil Mayfield Sr.</i>				2. DATE OF DEATH MONTH <i>04</i> DAY <i>20</i> YEAR <i>95</i>		3. TIME OF DEATH <i>5:40 AM</i>	
4. SOCIAL SECURITY NUMBER <i>221247253</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>55</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>6-28-40</i>	
8. BIRTHPLACE (State or Foreign Country) <i>Winnsboro, SC</i>				9a. FACILITY NAME (If not institution, give street and number) <i>Liberty Medical Center</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore</i>	
9c. COUNTY OF DEATH <i>Cecil</i>				10a. STATE <i>MD</i>			
10b. COUNTY <i>Cecil</i>				10c. CITY, TOWN OR LOCATION <i>Baltimore</i>			
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <i>2501 Violet Ave. Apt 905 North</i>			
10f. ZIP CODE <i>21215</i>				10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <i>7-23-1968</i>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>black</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>--</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>servicemen</i>		16b. KIND OF BUSINESS/INDUSTRY <i>U.S. Navy</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Samuel Mayfield</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Pearl Evans Mayfield</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Emma Mayfield</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>2501 Violet Ave Apt. 905 North Balt. MD 21215</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Dela. Vets. Mem. Ceme. 4-25</i>		20c. LOCATION — City or Town, State <i>Bear. DE</i>		21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Robert P. Wright</i>	
22. NAME AND ADDRESS OF FACILITY <i>The House of Wright Mortuary Inc. P.O. Box 447 Wilm., DE 19899</i>		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Lung Cancer</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <i>Lung Cancer</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>Seizure disorder</i> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>James L. King, MD</i>				29c. LICENSE NUMBER <i>D30119</i>		29d. DATE SIGNED (Month, Day, Year) <i>4-20-95</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>SITAKIDA SIDDIOI 6212 Sykesville Rd Sykesville 21784</i>							
31. DATE FILED (Month, Day, Year) <i>APR 25 1995</i>				32. REGISTRAR'S SIGNATURE <i>John Atwater Harrell</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13803

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Gilbert Bye Mackie</i>				2. DATE OF DEATH MONTH DAY YEAR 4-23-95		3. TIME OF DEATH 0053 M	
4. SOCIAL SECURITY NUMBER 222-07-1178		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 76 YRS.		7. DATE OF BIRTH (Month, Day, Year) 8-12-18	
9a. FACILITY NAME (If not institution, give street and number) Union Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Elkton		9c. COUNTY OF DEATH Cecil	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Cecil		10c. CITY, TOWN OR LOCATION Elkton		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 223 Hollingsworth Manor				10f. ZIP CODE 21921		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (6-12) 12 College (1-4 or 5+) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Jitney Driver		16b. KIND OF BUSINESS/INDUSTRY Chrysler Corp.			
17. FATHER'S NAME (First, Middle, Last) Harry McVey Mackie				18. MOTHER'S NAME (First, Middle, Maiden Surname) Dora Scott			
19a. INFORMANT'S NAME (Type/Print) Kenneth M. Mackie				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1624 Old Elk Neck Rd, Elkton, Md. 21921			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Sharps Cemetery 4/26/95		20c. LOCATION — City or Town, State Fair Hill, Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY Gee Funeral Home 259 E. Main St., Elkton, Md. 21921			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
a. <i>Negative Encephalopathy</i> DUE TO (OR AS A CONSEQUENCE OF):							
b. <i>Chronic liver with cirrhosis</i> DUE TO (OR AS A CONSEQUENCE OF):							
c. <i>Alcoholism</i> DUE TO (OR AS A CONSEQUENCE OF):							
d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Jui-mi Han MD</i>				29c. LICENSE NUMBER D04823		29d. DATE SIGNED (Month, Day, Year) 4/23/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Jui Chih Hsu, MD 223 West main st. Elkton Md 21921							
31. DATE FILED (Month, Day, Year) APR 25 1995				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.


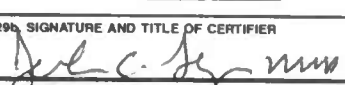
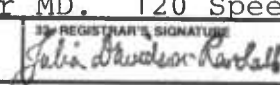
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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95 13804

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) B. Louise Mejia				2. DATE OF DEATH April 18 DAY 1995 YEAR				3. TIME OF DEATH 1855 M			
4. SOCIAL SECURITY NUMBER 260-07-8051		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 78 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) Nov. 29, 1916			
8. BIRTHPLACE (State or Foreign) Alabama				9a. FACILITY NAME (If not institution, give street and number) The Kent & Queen Anne's Hospital Inc. Chestertown MD				9b. CITY, TOWN OR LOCATION OF DEATH Kent			
RESIDENCE OF DECEDENT											
10a. STATE MARYLAND		10b. COUNTY CECIL		10c. CITY, TOWN OR LOCATION Georgetown				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER Box 87 4 Frederick St.				10f. ZIP CODE 21930		10g. CITIZEN OF WHAT COUNTRY? USA					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Machinist			16b. KIND OF BUSINESS/INDUSTRY Metal Equipment Manufacturing				
17. FATHER'S NAME (First, Middle, Last) Unknown				18. MOTHER'S NAME (First, Middle, Maiden Surname) Unknown							
19a. INFORMANT'S NAME (Type/Print) William M. Mejia				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Box 87 4 Frederick St. Georgetown, MD. 21930							
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Capitol Crematory 14-19			DATE Dover, DE.		20c. LOCATION — City or Town, State				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE  MO0510				22. NAME AND ADDRESS OF FACILITY Galena Funeral Home Of Stephen L Schaeck Box 235 Galena, MD. 21635							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ACUTE PNEUMONIA DUE TO (OR AS A CONSEQUENCE OF): b. ASPIRATION DUE TO (OR AS A CONSEQUENCE OF): c. PNEUMONIC DEMONIA DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death 6 mos. 2 yrs.											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D-13824		29d. DATE SIGNED (Month, Day, Year) 4-18-95					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John C. Seymour MD. 120 Speer Rd. Chestertown, MD. 21620											
31. DATE FILED (Month, Day, Year) APR 21 1995				32. REGISTRAR'S SIGNATURE 							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.


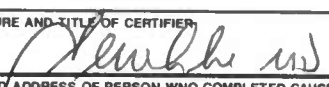
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13805

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Nellie Catherine Mullin				2. DATE OF DEATH MONTH DAY YEAR April 10, 1995		3. TIME OF DEATH 8:20 P.M.	
4. SOCIAL SECURITY NUMBER 214-09-8543		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 83 YRS.		7. DATE OF BIRTH (Month, Day, Year) 10-24-1911	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) Frederick Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Frederick	
9c. COUNTY OF DEATH Frederick				10a. STATE Maryland		10b. COUNTY Frederick	
10c. CITY, TOWN OR LOCATION Woodsboro				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 10122 Woodsboro Road	
10f. ZIP CODE 21798		10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 8		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Special Education Aide		16b. KIND OF BUSINESS/INDUSTRY School			
17. FATHER'S NAME (First, Middle, Last) Oliver Clinton Bowers				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Emma Catherine Baker			
19a. INFORMANT'S NAME (Type/Print) Mary A. Parsons				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10122 Woodsboro Rd. Woodsboro, MD 21798			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Rose Hill 4-13-95		20c. LOCATION — City or Town, State Clear Spring, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Thompson Funeral Home, Inc. P.O. Box 310 Clear Spring, MD 21722			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cerebrovascular accident DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. atherosclerotic cardiovascular disease DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death 3 wks 5 yd							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. pneumonia							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D3105P		29d. DATE SIGNED (Month, Day, Year) 4/11/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Gene Arhe MD 10200 Coppersmith Rd, Woodsboro, MD 21798							
31. DATE FILED (Month, Day, Year) APR 14 1995							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13806

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Albert Martin Moats				2. DATE OF DEATH MONTH April DAY 19 YEAR 1995		3. TIME OF DEATH 0306 A.M.	
4. SOCIAL SECURITY NUMBER 219-12-0964		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 67 YRS.		7. DATE OF BIRTH (Month, Day, Year) Sept. 11 1927	
9a. FACILITY NAME (If not institution, give street and number) Washington County Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Hagerstown		9c. COUNTY OF DEATH Washington	
10a. STATE Maryland		10b. COUNTY Washington		10c. CITY, TOWN OR LOCATION Williamsport		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 1-F Milestone Garden Apartments				10f. ZIP CODE 21795		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES W.W. II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) College (1-4 or 5+)		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Fork Lift Operator		15b. KIND OF BUSINESS/INDUSTRY Auto Manufacturer			
17. FATHER'S NAME (First, Middle, Last) Luther Moats				18. MOTHER'S NAME (First, Middle, Maiden Surname) Anna Kline			
19a. INFORMANT'S NAME (Type/Print) Mary Ann Moats				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1-F Milestone Garden Apt. Williamsport, Md. 21795			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Greenlawn Memorial Park 4-22-95		20c. LOCATION — City or Town, State Williamsport, Md.		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Scott M. Munnick				22. NAME AND ADDRESS OF FACILITY Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 21740			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cardiogenic Shock Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST End Stage - cardiomyopathy DUE TO (OR AS A CONSEQUENCE OF): 5 yrs DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Dr. G. Papuchis				29c. LICENSE NUMBER D32 P51		29d. DATE SIGNED (Month, Day, Year) 4/19/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. G. Papuchis 354 M. 11 Street Hagerstown Md 21740							
31. DATE FILED (Month, Day, Year) APR 20 1995				32. REGISTRAR'S SIGNATURE Johanna K. Kroll			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13807

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ANNABELLE CATHERINE MOORE				2. DATE OF DEATH MONTH DAY YEAR April 16, 1995		3. TIME OF DEATH 5:00 a.m.	
4. SOCIAL SECURITY NUMBER 214-09-2001		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 79 YRS.	7. DATE OF BIRTH (Month, Day, Year) 11-20-1915		8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not institution, give street and number) 532 West Howard Street				9b. CITY, TOWN OR LOCATION OF DEATH Hagerstown		9c. COUNTY OF DEATH Washington	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Washington		10c. CITY, TOWN OR LOCATION Hagerstown		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 1548 Mt. Aetna Road				10f. ZIP CODE 21742		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 years College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Bookkeeper		16b. KIND OF BUSINESS/INDUSTRY Dairy Industry			
17. FATHER'S NAME (First, Middle, Last) John Edward Alter				18. MOTHER'S NAME (First, Middle, Maiden Surname) Lottie C. Ridge			
19a. INFORMANT'S NAME (Type/Print) E. Ann Swope				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1548 Mt. Aetna Road Hagerstown, Maryland 21742			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) St. Paul's Cemetery 4-19-1995		20c. LOCATION — City or Town, State Clear Spring, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Douglas A. Fiery</i>				22. NAME AND ADDRESS OF FACILITY Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown, Md.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. Acute Myocardial Infarction					Approximate Interval Between Onset and Death 10 minutes
		b. Valvular Heart Disease					60 years
Sequitely conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		c. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) Care giver's home					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURRED			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Robert Brull, M.D., Physician</i>				29c. LICENSE NUMBER D04359		29d. DATE SIGNED (Month, Day, Year) 4/17/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) Robert Brull 1459 Potomac Ave Hagerstown MD 21742							
31. DATE FILED (Month, Day, Year) APR 18 1995		32. REGISTRAR'S SIGNATURE <i>John Brundage</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1. 3. 12. 1950

95 13808

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) RALPH WILLIS MOORE				2. DATE OF DEATH MONTH April DAY 12 YEAR 1995		3. TIME OF DEATH 324 PM	
4. SOCIAL SECURITY NUMBER 173-03-0351		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 81 YRS.		7. DATE OF BIRTH MONTH JULY DAY 14 YEAR 1913	
9a. FACILITY NAME (If not institution, give street and number) WASHINGTON COUNTY HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH HAGERSTOWN		9c. COUNTY OF DEATH WASHINGTON	
10a. STATE MARYLAND		10b. COUNTY WASHINGTON		10c. CITY, TOWN OR LOCATION HAGERSTOWN		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 1420 HAMILTON BLVD.				10f. ZIP CODE 21742		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) ELECTRICIAN ENGINEER		15b. KIND OF BUSINESS/INDUSTRY BLAST CLEANING EQUIP.			
17. FATHER'S NAME (First, Middle, Last) RALPH WILLIS MOORE				18. MOTHER'S NAME (First, Middle, Maiden Surname) MINNIE MAE KING			
19a. INFORMANT'S NAME (Type/Print) ELIZABETH M. MOORE				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1420 HAMILTON BLVD., HAGERSTOWN, MD. 21742			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) SMITHSBURG CREMATORY 04-13-95		20c. LOCATION — City or Town, State HAGERSTOWN, MARYLAND		20d. DATE 04-13-95	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>R. Noel Brady</i>				22. NAME AND ADDRESS OF FACILITY ANDREW K. COFFMAN FUNERAL HOME, INC. 40 E. ANTIETAM STREET, HAGERSTOWN, MD. 21740			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Congestive Heart Failure</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>Pulmonary Fibrosis</i> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate interval Between Onset and Death <i>2 yrs.</i> <i>years</i>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DCA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John H. [Signature]</i>				29c. LICENSE NUMBER 021457		29d. DATE SIGNED (Month, Day, Year) 4/12/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ABDUL WATZED, MD - 12821 - OAKHILL AVE. HAGERSTOWN, MD							
31. DATE FILED (Month, Day, Year) APR 13 1995							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020


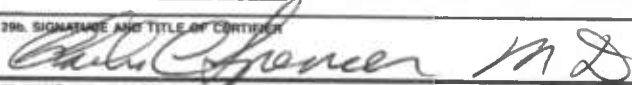

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13809

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) Mary Geneva MENTZER				2. DATE OF DEATH MONTH April DAY 20, YEAR 1995				3. TIME OF DEATH 1:30 P M			
4. SOCIAL SECURITY NUMBER 220-05-6634		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 79 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) Dec. 5, 1915		8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not institution, give street and number) 55 S. Potomac St., Apt. 302				9b. CITY, TOWN OR LOCATION OF DEATH Hagerstown				9c. COUNTY OF DEATH Washington			
RESIDENCE OF DECEASED											
10a. STATE Maryland		10b. COUNTY Washington		10c. CITY, TOWN OR LOCATION Hagerstown				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER 55 S. Potomac Street, Apt. 302				10f. ZIP CODE 21740				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: white			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) 0				15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) homemaker				15b. KIND OF BUSINESS/INDUSTRY her own home			
17. FATHER'S NAME (First, Middle, Last) John Wesley Bowman						18. MOTHER'S NAME (First, Middle, Maiden Surname) Emma Seibert					
19a. INFORMANT'S NAME (Type/Print) Jean Marquiss				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 620 Salem Ave., Hagerstown, Maryland 21740							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Rest Haven Cemetery 4-22-95				20c. LOCATION — City or Town, State Hagerstown, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Chronic renal failure present for two years DUE TO (OR AS A CONSEQUENCE OF): b. due to Diabetes Mellitus, Insulin dependent DUE TO (OR AS A CONSEQUENCE OF): c. present for five years DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST										Approximate interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28b. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER 						29c. LICENSE NUMBER D11133		29d. DATE SIGNED (Month, Day, Year) 4-21-95			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Charles C. Spencer, M.D., 1198 Kenly Ave., Hagerstown, Md. 21740											
31. DATE FILED (Month, Day, Year) APR 21 1995				32. REGISTRAR'S SIGNATURE 							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13810

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) David Theodore McKEE				2. DATE OF DEATH MONTH 4 DAY 21 YEAR 95		3. TIME OF DEATH 1700 HRS.	
4. SOCIAL SECURITY NUMBER 212-14-6542		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 75 YRS.	7. DATE OF BIRTH (Month, Day, Year) Jan. 16, 1920	8. BIRTHPLACE (State or Foreign Country) Maryland		
9a. FACILITY NAME (If not institution, give street and number) Washington County Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Hagerstown		9c. COUNTY OF DEATH WASHINGTON	
10a. STATE Maryland		10b. COUNTY Washington		10c. CITY, TOWN OR LOCATION Clear Spring		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 15620 Broadfording Rd.				10f. ZIP CODE 21722		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 1		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Personnel Manager		16b. KIND OF BUSINESS/INDUSTRY Aircraft Manufacture			
17. FATHER'S NAME (First, Middle, Last) David (NMI) McKee				18. MOTHER'S NAME (First, Middle, Maiden Surname) Rosa Viola Chaney			
19a. INFORMANT'S NAME (Type/Print) Bernice K. McKee				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15620 Broadfording Rd. Clear Spring, MD 21722			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Pinesburg Mennonite Cem. 4/25/95		20c. LOCATION — City or Town, State Williamsport, MD 21795		20d. DATE 4/25/95	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY OSBORNE FUNERAL HOME P.O. Box # 348 Williamsport, MD 21795			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ACUTE CARDIO PULMONARY ARREST DUE TO (OR AS A CONSEQUENCE OF): b. PULMONARY EDEMA DUE TO (OR AS A CONSEQUENCE OF): c. CORONARY ARTERY DISEASE DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PANCREATIC TUMOR HISTORY OF COLONIAL PROSTATE CANCER DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER D44555		29d. DATE SIGNED (Month, Day, Year) 4/21/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 3019 VENTURE CT MYERSVILLE MD. 21773							
APR 24 1995 <i>[Signature]</i> 32. REGISTRAR'S SIGNATURE							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

NOT A REPRODUCIBLE COPY OF THE

95 13811

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Arthur Morton Meranski				2. DATE OF DEATH MONTH DAY YEAR April 17, 1995				3. TIME OF DEATH 4:20P M					
4. SOCIAL SECURITY NUMBER 048-09-1931		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 75 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) 12/1/1919		8. BIRTHPLACE (State or Foreign Country) Connecticut			
9a. FACILITY NAME (If not institution, give street and number) Perry Point VAMC				9b. CITY, TOWN OR LOCATION OF DEATH Perry Point				9c. COUNTY OF DEATH Cecil					
RESIDENCE OF DECEDENT													
10a. STATE Maryland		10b. COUNTY Harford		10c. CITY, TOWN OR LOCATION Aberdeen				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
10e. STREET AND NUMBER 836 Randolph Drive				10f. ZIP CODE 21001				10g. CITIZEN OF WHAT COUNTRY? USA					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II, Korean		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No -- If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE -- American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Military				16b. KIND OF BUSINESS/INDUSTRY U.S. Army					
17. FATHER'S NAME (First, Middle, Last) Harry Meranski						18. MOTHER'S NAME (First, Middle, Maiden Surname) Sarah Taylor							
19a. INFORMANT'S NAME (Type/Print) Betty J. Meranski						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 836 Randolph Dr. Aberdeen, MD 21001							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Arlington National Cemt. 4/25		20c. LOCATION -- City or Town, State Arlington, Virginia							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Kirsten Amyengesbee						22. NAME AND ADDRESS OF FACILITY Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cancer of Lung with Metastasis of Brain DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.										Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.													
24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO									
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY -- At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER Vijay K. Nellore M.D.						29c. LICENSE NUMBER D21779		29d. DATE SIGNED (Month, Day, Year) 4-17-95					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) VIJAY K. NELLORE, M.D., VA Medical Center, Perry Point, MD 21902													
31. DATE FILED (Month, Day, Year) APR 21 1995						32. REGISTRAR'S SIGNATURE John Andrew Randall							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13812

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) James Bruce MAHAN				2. DATE OF DEATH MONTH 4 DAY 18 YEAR 95		3. TIME OF DEATH 8:00A M	
4. SOCIAL SECURITY NUMBER 484-26-2268		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 68 YRS.		7. DATE OF BIRTH (Month, Day, Year) 11-6-26	
9a. FACILITY NAME (If not Institution, give street and number) 302 St. Ives Drive				9b. CITY, TOWN OR LOCATION OF DEATH Severna Park		9c. COUNTY OF DEATH Anne Arundel	
10a. STATE Maryland				10b. COUNTY Anne Arundel		10c. CITY, TOWN OR LOCATION Severna Park	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER 302 St. Ives Drive				10f. ZIP CODE 21146		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Public Affairs		16b. KIND OF BUSINESS/INDUSTRY U.S. Customs	
17. FATHER'S NAME (First, Middle, Last) FRANK T. MAHAN				18. MOTHER'S NAME (First, Middle, Maiden Surname) MARGARET R. MOECK			
19a. INFORMANT'S NAME (Type/Print) James M. Mahan				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 224 Finnegan Drive Millersville MD 21108			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MD Veterans Cemetery 4-21-95 Crownsville, MD		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Robert B.				22. NAME AND ADDRESS OF FACILITY Barranco and Sons Funeral Home 495 Ritchie Hwy Severna Park MD 21146			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → VENTRICULAR ARRYTHMIA DUE TO (OR AS A CONSEQUENCE OF): Ischemic cardiovascularopathy DUE TO (OR AS A CONSEQUENCE OF): Coronary artery disease DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST 4 years 4 years							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Gerard Blumel				29c. LICENSE NUMBER NO 1861		29d. DATE SIGNED (Month, Day, Year) 4/18/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) GERARD CHURCH, AAMC, Annapolis, MD							
31. DATE FILED (Month, Day, Year) APR 21 1995				32. REGISTRAR'S SIGNATURE John A. Davis			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13813

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Laura C. McCall</i> - Laura Cynthia McCall				2. DATE OF DEATH MONTH <i>4</i> DAY <i>13</i> YEAR <i>95</i>		3. TIME OF DEATH <i>1:50 PM</i>	
4. SOCIAL SECURITY NUMBER <i>216-76-4537</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>27</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>4/27/68</i>	
8. BIRTHPLACE (State or Foreign Country) <i>Maryland</i>				9a. FACILITY NAME (If not institution, give street and number) <i>710 Hances Point Road</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>North East</i>	
9c. COUNTY OF DEATH <i>Cecil</i>				10a. STATE <i>Maryland</i>		10b. COUNTY <i>Cecil</i>	
10c. CITY, TOWN OR LOCATION <i>North East</i>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <i>710 Hances Point Road</i>	
10f. ZIP CODE <i>21901</i>				10g. CITIZEN OF WHAT COUNTRY? <i>United States</i>			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>College</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Legal Secretary</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Attorney's Office</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Wilmer C. McCall, Jr.</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Gladys Miller</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Wilmer C. McCall, Jr.</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>706 Hances Point Road, North East, MD 21901</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>North East Methodist Cem. 4/17</i>		20c. LOCATION — City or Town, State <i>North East, Maryland</i>		21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Robert D. Crouch</i>	
22. NAME AND ADDRESS OF FACILITY <i>Crouch Funeral Home</i>		22. NAME AND ADDRESS OF FACILITY <i>127 South Main Street, North East MD 21901</i>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>a. Metastatic ovarian Cancer of Cervix -</i>							
DUE TO (OR AS A CONSEQUENCE OF):							
b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John D. Harkins, M.D.</i>				29c. LICENSE NUMBER <i>D 33099</i>		29d. DATE SIGNED (Month, Day, Year) <i>4/13/95</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>RE OMILA SURF 138 Cathedral Hotel, ELKTON MD</i>							
31. DATE FILED (Month, Day, Year) <i>APR 14 1995</i>		32. REGISTRAR'S SIGNATURE <i>John D. Harkins</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13814

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Mildred B. Malcolm				2. DATE OF DEATH MONTH DAY YEAR 4-11-95		3. TIME OF DEATH 10:04 A. M	
4. SOCIAL SECURITY NUMBER 221-22-6750		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 88 YRS.		7. DATE OF BIRTH (Month, Day, Year) 8-2-06	
9a. FACILITY NAME (If not institution, give street and number) 315 George Street				9b. CITY, TOWN OR LOCATION OF DEATH Chesapeake City		9c. COUNTY OF DEATH Cecil	
10a. STATE Maryland				10b. COUNTY Cecil		10c. CITY, TOWN OR LOCATION Chesapeake City	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 315 George Street			
10f. ZIP CODE 21915				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (14 or 5+) 11		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Retail Sales		16b. KIND OF BUSINESS/INDUSTRY Department Store			
17. FATHER'S NAME (First, Middle, Last) Alec B. Richardson				18. MOTHER'S NAME (First, Middle, Maiden Surname) Clara E. Cottingham			
19a. INFORMANT'S NAME (Type/Print) Judith A. Staker				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 315 George St., Chesapeake City, Md. 21915			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) R. A. Ferris & Co. 4/12		20c. LOCATION — City or Town, State West Chester, Pa.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY Gee Funeral Home 259 E. Main St., Elkton, Md. 21921			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Metastatic breast cancer</i> DUE TO (OR AS A CONSEQUENCE OF): b. _____ DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>		29c. LICENSE NUMBER 045155		29d. DATE SIGNED (Month, Day, Year) 12/10/05	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John Mulvey, M.D. 118 North Street, Elkton, Md. 21921							
31. DATE FILED (Month, Day, Year) APR 12 1995		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13815

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) William M. McAllister				2. DATE OF DEATH MONTH April DAY 8 YEAR 1995				3. TIME OF DEATH 7:45 P. M.	
4. SOCIAL SECURITY NUMBER 215-36-0398		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 55 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS. HOURS 0 MIN. 0		7. DATE OF BIRTH (Month, Day, Year) 9/2/1932	
9a. FACILITY NAME (If not Institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER				9b. CITY, TOWN OR LOCATION OF DEATH SALISBURY				9c. COUNTY OF DEATH WICOMICO	
RESIDENCE OF DECEDENT									
10a. STATE Delaware		10b. COUNTY Sussex		10c. CITY, TOWN OR LOCATION Laurel				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 3 Millcreek Circle				10f. ZIP CODE 19956		10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES Airforce		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Insulation Mechanic			16b. KIND OF BUSINESS/INDUSTRY		
17. FATHER'S NAME (First, Middle, Last) Alfred Edward McAllister				18. MOTHER'S NAME (First, Middle, Maiden Surname) Elva Louise Workman					
19a. INFORMANT'S NAME (Type/Print) Brian P. McAllister				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) PO BOX 673, Pocomoke City, Md. 21851					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Pitts Creek Presbyterian Cem.			DATE 4/12		20c. LOCATION — City or Town, State Pocomoke City, Maryland		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Scott S. Melson</i>				22. NAME AND ADDRESS OF FACILITY Melson Funeral Home PO Box 64, Pocomoke City, Md. 21851					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Diffuse Large Cell Lymphoma DUE TO (OR AS A CONSEQUENCE OF): Sequitally ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.									Approximate Interval Between Onset and Death 6 months
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>J. E. Martin</i>				29c. LICENSE NUMBER 030690			29d. DATE SIGNED (Month, Day, Year) 4/8/95		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) James E. Martin, M.D., 145 E. Carroll St., Salisbury, MD									
31. DATE FILED (Month, Day, Year) APR 12 1995				32. REGISTRAR'S SIGNATURE <i>John Davidson</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13816

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Walter Edison Miller				2. DATE OF DEATH MONTH: April DAY: 10 YEAR: 1995		3. TIME OF DEATH 5:45 P.M.	
4. SOCIAL SECURITY NUMBER 063-24-2147		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 81 YRS.	IF UNDER 1 YEAR MONTHS: _____ DAYS: _____	IF UNDER 24 HRS. HOURS: _____ MIN.: _____	7. DATE OF BIRTH (Month, Day, Year) Jan. 28, 1914	
8. BIRTHPLACE (State or Foreign Country) New York				9a. FACILITY NAME (If not institution, give street and number) Fallston General Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Fallston	
9c. COUNTY OF DEATH Harford				10a. STATE Maryland		10b. COUNTY Harford	
10c. CITY, TOWN OR LOCATION Bel Air				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 25 Bonnie Ave.	
10f. ZIP CODE 21014				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: _____			
14. RACE — American Indian, Black, White, etc. Specify: White				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) _____ College (1-4 or 5+) 5+			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Professor of Chemistry				16b. KIND OF BUSINESS/INDUSTRY Education			
17. FATHER'S NAME (First, Middle, Last) Louis (nmn) Miller				18. MOTHER'S NAME (First, Middle, Maiden Surname) Hattie (nmn) Rose			
19a. INFORMANT'S NAME (Type/Print) Elizabeth Miller				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25 Bonnie Ave., Bel Air, Md. 21014			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) _____				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) DATE West Ridgeland Cemetery 4-13-95			
20c. LOCATION — City or Town, State Clifton, New Jersey				21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>			
22. NAME AND ADDRESS OF FACILITY Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, Md. 21009				23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sepsis secondary to Urinary Tract Infection 1wk. Sequitely ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. Hyperosmolar state b. Uncontrolled Diabetes c. Dehydration			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Azotemia, Hypernatremia, Prior strokes, Parkinson's Disease.				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO				DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>J.K. Lynch MD.</i>			
29c. LICENSE NUMBER D35012				29d. DATE SIGNED (Month, Day, Year) 4/11/95			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J.K. LYNCH MD. 2 North Ave. Bel Air, Md.							
31. DATE FILED (Month, Day, Year) APR 12 1995							
32. REGISTRAR'S SIGNATURE <i>[Signature]</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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95 138171 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Merrell Caudill Mullen</u>				2. DATE OF DEATH MONTH <u>04</u> DAY <u>03</u> YEAR <u>95</u>		3. TIME OF DEATH <u>8:35 p.m.</u>					
4. SOCIAL SECURITY NUMBER <u>218-32-7659</u>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>96</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>11/24/1898</u>		8. BIRTHPLACE (State or Foreign Country) <u>Kentucky</u>			
9a. FACILITY NAME (If not institution, give street and number) <u>Ivy Hall Geriatric Center</u>				9b. CITY, TOWN OR LOCATION OF DEATH <u>Baltimore</u>			9c. COUNTY OF DEATH <u>Baltimore</u>				
10a. STATE <u>Maryland</u>		10b. COUNTY <u>Harford</u>		10c. CITY, TOWN OR LOCATION <u>Jarrettsville</u>			10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				
10e. STREET AND NUMBER <u>1628 Dulaney Drive</u>				10f. ZIP CODE <u>21084</u>		10g. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <u>White</u>				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>11</u> College (14 or 5+) <u>--</u>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Housewife</u>			16b. KIND OF BUSINESS/INDUSTRY <u>Home</u>						
17. FATHER'S NAME (First, Middle, Last) <u>Henry C. Caudill</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Rebecca Pennington</u>							
19a. INFORMANT'S NAME (Type/Print) <u>Madlyn Meister</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>same as #10</u>							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Highview Mem. Gardens 4/6</u>			20c. LOCATION — City or Town, State <u>Fallston, Maryland</u>						
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>M. Bladden Kurtz</u>				22. NAME AND ADDRESS OF FACILITY <u>Kurtz Funeral Home</u> <u>Jarrettsville, Maryland</u>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Sepsis</u> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): <u>Recurrent aspiration Pneumonia</u> b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death <u>5 day</u> <u>one week</u>											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>① Severe Malnutrition.</u> <u>② Coronary artery disease / Atrial fibrillation</u> <u>③ Anemia.</u> <u>④ Dehydration.</u>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <u>Malika Wassem MD</u>				29c. LICENSE NUMBER <u>D-38754</u>		29d. DATE SIGNED (Month, Day, Year) <u>4-6-95</u>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>MALIKA WASSEM. 100. N. BROADWAY, BALTIMORE, MD-21231.</u>											
31. DATE FILED (Month, Day, Year) <u>APR 12 1995</u>				32. REGISTRAR'S SIGNATURE <u>Jubin Davidson-Randall</u>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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95 13818

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MAURICE HARRY MILLER				2. DATE OF DEATH MONTH 4 DAY 14 YEAR 1995		3. TIME OF DEATH 1:00 A M	
4. SOCIAL SECURITY NUMBER 204-03-2248		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 72 YRS.		7. DATE OF BIRTH (Month, Day, Year) SEPT. 14, 1922	
8. BIRTHPLACE (State or Foreign Country) PENNSYLVANIA				9. FACILITY NAME (If not institution, give street and number) CARROLL COUNTY GENERAL HOSPITAL		10. CITY, TOWN OR LOCATION OF DEATH WESTMINSTER	
11. COUNTY OF DEATH CARROLL				12. RESIDENCE OF DECEDENT 10a. STATE MARYLAND 10b. COUNTY CARROLL 10c. CITY, TOWN OR LOCATION TANEYTOWN 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		13. STREET AND NUMBER 3112 ROOP ROAD	
14. ZIP CODE 21787				15. CITIZEN OF WHAT COUNTRY? USA		16. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
17. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				18. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		19. RACE — American Indian, Black, White, etc. Specify: CAUCASIAN	
20. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10th College (1-4 or 5+) College				21. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) TRUCK DRIVER		22. KIND OF BUSINESS/INDUSTRY TRUCKING	
23. FATHER'S NAME (First, Middle, Last) HARVEY ABRHAM MILLER				24. MOTHER'S NAME (First, Middle, Maiden Surname) MARGARET FRANCES RILEY			
25. INFORMANT'S NAME (Type/Print) DEBORAH D. BAUGHER				26. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3112 roop road TANEYTOWN, MARYLAND 21787			
27. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				28. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) RESTHAVEN CEMETERY 4/18		29. LOCATION — City or Town, State HANOVER, PENNSYLVANIA	
30. SIGNATURE OF FUNERAL SERVICE LICENSEE P. Kevin Judy				31. NAME AND ADDRESS OF FACILITY 136 EAST BALTIMORE STREET SKILES FUNERAL HOME TANEYTOWN, MD 21787			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Gangrene leg with sepsis DUE TO (OR AS A CONSEQUENCE OF): a. pneumonia b. Myocardial infarction (acute) c. Myocardial infarction (acute) d. Myocardial infarction (acute) SEQUENTIALLY list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
32. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		33. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
34. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		35. DATE OF INJURY (Month, Day, Year)		36. TIME OF INJURY M		37. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
38. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		39. DESCRIBE NOW INJURY OCCURRED					
40. LOCATION (Street and Number or Rural Route Number, City or Town, State)		41. DATE SIGNED (Month, Day, Year) 4/14/95					
42. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
43. SIGNATURE AND TITLE OF CERTIFIER [Signature]				44. LICENSE NUMBER		45. DATE SIGNED (Month, Day, Year) 4/14/95	
46. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 20 CROSSROADS DRIVE, SUITE 210 OWINGS MILLS MD 21117							
47. DATE FILED (Month, Day, Year) APR 17 1995				48. REGISTRAR'S SIGNATURE [Signature]			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13819

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Milton Alexander Noon				2. DATE OF DEATH MONTH April 15, 1995 DAY YEAR		3. TIME OF DEATH 6:00 P M	
4. SOCIAL SECURITY NUMBER 179-36-0038		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 91 YRS.		7. DATE OF BIRTH (Month, Day, Year) Jan. 1, 1904	
8. BIRTHPLACE (State or Foreign Country)				9a. FACILITY NAME (If not institution, give street and number) Millersville Home Care		9b. CITY, TOWN OR LOCATION OF DEATH Severna Park	
9c. COUNTY OF DEATH Anne Arundel				10a. STATE Maryland			
10b. COUNTY Dorchester				10c. CITY, TOWN OR LOCATION Woolford			
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 1656 Taylors Island Road			
10f. ZIP CODE 21677				10g. CITIZEN OF WHAT COUNTRY? US			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Medical Doctor		16b. KIND OF BUSINESS/INDUSTRY General Practice			
17. FATHER'S NAME (First, Middle, Last) Milton Alexander Noon, Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Carolyn Claus			
19a. INFORMANT'S NAME (Type/Print) Eleanor Noon Triplett				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 464 Holly Farms Rd. Severna Park, Md. 21146			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Old Trinity Churchyard 4/18		20c. LOCATION — City or Town, State Churuch Creek, Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Thomas Funeral Home 700 Locust St. Cambridge, Maryland 21613			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <u>Pneumonia</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>Peritonitis Disease</u> DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Approximate Interval Between Onset and Death 1 week 3 years							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D08743		29d. DATE SIGNED (Month, Day, Year) 4/18/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Ben Oates Professional Center 831 W Benfield Rd Severna Park MD 21146							
31. DATE FILED (Month, Day, Year) APR 19 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13820

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Lulu Po Noordermeer</u>				2. DATE OF DEATH MONTH <u>April</u> DAY <u>13</u> YEAR <u>95</u>		3. TIME OF DEATH <u>1:02 A M</u>	
4. SOCIAL SECURITY NUMBER <u>217.42.8262</u>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <u>76</u> YRS.	7. DATE OF BIRTH (Month, Day, Year) <u>JAN. 19, 1919</u>		8. BIRTHPLACE (State or Foreign Country) <u>MOULNEIN, MYANMAR</u>	
9a. FACILITY NAME (If not institution, give street and number) <u>SUBURBAN HOSPITAL</u>				9b. CITY, TOWN OR LOCATION OF DEATH <u>BETHESDA</u>		9c. COUNTY OF DEATH <u>MONTGOMERY</u>	
RESIDENCE OF DECEDENT							
10a. STATE <u>MARYLAND</u>		10b. COUNTY <u>MONTGOMERY</u>		10c. CITY, TOWN OR LOCATION <u>CHEVY CHASE</u>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <u>5081 BRADLEY BLVD. APT. 107</u>				10f. ZIP CODE <u>20815</u>		10g. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>WHITE</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u></u>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>HOMEMAKER</u>		16b. KIND OF BUSINESS/INDUSTRY <u>OWN HOME</u>	
17. FATHER'S NAME (First, Middle, Last) <u>PO</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>U PO</u>			
19a. INFORMANT'S NAME (Type/Print) <u>JEFF R. NOORDERMEER</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>5081 BRADLEY BLVD. APT. 107 CHEVY CHASE, MD. 20815</u>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>GATE OF HEAVEN</u>		DATE <u>4/17</u>		20c. LOCATION — City or Town, State <u>SILVER SPRING, MD.</u>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Jack M Peters</u>				22. NAME AND ADDRESS OF FACILITY <u>JOSEPH GAWLER'S SONS</u> <u>5130 WI AVE NW WASHINGTON DC 20016</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Cerebrovascular accident</u>							
DUE TO (OR AS A CONSEQUENCE OF):							
b. <u>Fractured Right Hip</u>							
DUE TO (OR AS A CONSEQUENCE OF):							
c. <u></u>							
DUE TO (OR AS A CONSEQUENCE OF):							
d. <u></u>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <u>April 3 95</u>		28b. TIME OF INJURY <u>9 M</u>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED <u>Fell with Walker</u>		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <u>Home</u>		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <u>5081 BRADLEY BLVD.</u>	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <u>John T. Anderson MD</u>				29c. LICENSE NUMBER <u>208746</u>		29d. DATE SIGNED (Month, Day, Year) <u>April 14 95</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>John T. Anderson MD 8718 Wisconsin Ave</u>							
31. DATE FILED (Month, Day, Year) <u>APR 18 1995</u>		32. REGISTRAR'S SIGNATURE <u>John T. Anderson</u>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13821

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) NEU NEKRICH				2. DATE OF DEATH MONTH April DAY 17 YEAR 95				3. TIME OF DEATH 1:00 PM		
4. SOCIAL SECURITY NUMBER 083-38-4387		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 45 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0	IF UNDER 24 HRS. HOURS 0 MIN. 0	7. DATE OF BIRTH (Month, Day, Year) NOV. 5, 1949		8. BIRTHPLACE (State or Foreign Country) NEW YORK		
9a. FACILITY NAME (If not institution, give street and number) MONTGOMERY GENERAL HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH OLNEY			9c. COUNTY OF DEATH MONTGOMERY			
RESIDENCE OF DECEDENT										
10a. STATE MARYLAND		10b. COUNTY MONTGOMERY		10c. CITY, TOWN OR LOCATION BROOKEVILLE			10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 19440 JAMES CREEK COURT				10f. ZIP CODE 20833		10g. CITIZEN OF WHAT COUNTRY? UNITED STATES				
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR OATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: WHITE			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) 4				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) LOCATION MANAGER			16b. KIND OF BUSINESS/INDUSTRY INSURANCE			
17. FATHER'S NAME (First, Middle, Last) IRVING NEKRICH				18. MOTHER'S NAME (First, Middle, Maiden Surname) LEE KALKSTEIN						
19a. INFORMANT'S NAME (Type/Print) DENISE NEKRICH (WIFE)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19440 JAMES CREEK COURT-BROOKEVILLE, MARYLAND 20833						
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) NEW MONTEFIORE CEMETERY 4/18			OATE		20c. LOCATION — City or Town, State PINELAWN, NEW YORK			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE-ROCKVILLE, MD. 20852						
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>arteriosclerotic Heart Disease</u> DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.									Approximate Interval Between Onset and Death 1 year	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>										
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER 708546		29d. DATE SIGNED (Month, Day, Year) April 17 95				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John Tumber 8218 Wisconsin Ave Bethesda										
31. DATE FILED (Month, Day, Year) APR 18 1995				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>						

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13822

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MILDRED B. NEWCOMB				2. DATE OF DEATH MONTH APRIL DAY 16 , YEAR 1995		3. TIME OF DEATH 5:50 P M	
4. SOCIAL SECURITY NUMBER 091-05-6221		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 90 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 16, 1904	
8. BIRTHPLACE (State or Foreign Country) New York				9a. FACILITY NAME (If not institution, give street and number) Circle Manor Nursing Center		9b. CITY, TOWN OR LOCATION OF DEATH Kensington	
9c. COUNTY OF DEATH Montgomery				10a. STATE Maryland		10b. COUNTY Montgomery	
10c. CITY, TOWN OR LOCATION Kensington				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 10231 Carroll Place	
10f. ZIP CODE 20895				10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife		16b. KIND OF BUSINESS/INDUSTRY Own Home	
17. FATHER'S NAME (First, Middle, Last) Thomas Jefferson Bird				18. MOTHER'S NAME (First, Middle, Maiden Surname) Julienne Rodgers			
19a. INFORMANT'S NAME (Type/Print) Bazil W. Brown, Jr. (Son)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1101 New Hampshire Ave, NW #410, Washington, DC 20037			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Chesapeake Crematory		DATE 4-17		20c. LOCATION — City or Town, State Beltsville, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE MO0827				22. NAME AND ADDRESS OF FACILITY Rapp Funeral Services, P.A. 933 Gist Ave, Silver Spring, MD 20910			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ASPIRATION PNEUMONIA DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. SEVERE DEMENTIA DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death One Week Years							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURRED					
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER Martin C. Shargel, M.D.				29c. LICENSE NUMBER D08944		29d. DATE SIGNED (Month, Day, Year) April 17, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Martin C. Shargel, M.D. 3720 Farragut Avenue, Kensington, MD 20895-2110							
31. DATE FILED (Month, Day, Year) APR 18 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13823

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Beauveau B. Nalle				2. DATE OF DEATH MONTH DAY YEAR April 18, 1995				3. TIME OF DEATH 1548 M	
4. SOCIAL SECURITY NUMBER 185.20.4776		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 68 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7. DATE OF BIRTH (Month, Day, Year) Feb. 17, 1927				8. BIRTHPLACE (State or Foreign Country) Pennsylvania					
9a. FACILITY NAME (If not institution, give street and number) Suburban Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Bethesda				9c. COUNTY OF DEATH Montgomery	
RESIDENCE OF DECEDENT									
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Chevy Chase				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 4204 Maple Terrace				10f. ZIP CODE 20815		10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+				15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Foreign Service Officer				15b. KIND OF BUSINESS/INDUSTRY State Department	
17. FATHER'S NAME (First, Middle, Last) Albert Nalle				18. MOTHER'S NAME (First, Middle, Maiden Surname) Patty Borie					
19a. INFORMANT'S NAME (Type/Print) Elizabeth Nalle				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3501 Gamma Place Annadale, Va. 22003					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Rock Creek Cemetery		DATE 4/22		20c. LOCATION — City or Town, State Washington D.C.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Vernon Simmons</i>				22. NAME AND ADDRESS OF FACILITY Joseph Gawler's Sons 5130 WI AVE NW WASHINGTON DC 20016					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>intracerebral Bleed</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>cardiac arrhythmias</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i>nephrosclerosis</i> DUE TO (OR AS A CONSEQUENCE OF): d. Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Gita Chopra Bakshi</i>				29c. LICENSE NUMBER 023170		29d. DATE SIGNED (Month, Day, Year) April 19, 95			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Gita Chopra Bakshi, M.D. 9406 Old Georgetown Rd. Bethesda, Md. 20814-1722									
31. DATE FILED (Month, Day, Year) APR 21 1995				32. REGISTRAR'S SIGNATURE <i>John D. ...</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13824

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) TU Thi NGUYEN				2. DATE OF DEATH MONTH April DAY 13 YEAR 1995		3. TIME OF DEATH 9:51 a m	
4. SOCIAL SECURITY NUMBER 216-33-3038		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 64 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0	IF UNDER 24 HRS. HOURS 0 MIN. 0	7. DATE OF BIRTH (Month, Day, Year) Dec. 31, 1930	
8. BIRTHPLACE (State or Foreign Country) Vietnam				9a. FACILITY NAME (If not institution, give street and number) Doctor's Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Lanham	
9c. COUNTY OF DEATH Prince Georges				10a. STATE Maryland		10b. COUNTY Montgomery	
10c. CITY, TOWN OR LOCATION Silver Spring				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 9628 Cottrell Terrace	
10f. ZIP CODE 20903				10g. CITIZEN OF WHAT COUNTRY? Vietnam		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Vietnamese	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home	
17. FATHER'S NAME (First, Middle, Last) Nhung Nguyen				18. MOTHER'S NAME (First, Middle, Maiden Surname) Nhieu Dao			
19a. INFORMANT'S NAME (Type/Print) Hung To				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1500 Oakview Drive, Silver Spring, Maryland 20903			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Fort Lincoln Crematory 4/17		20c. LOCATION — City or Town, State Brentwood, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Laine L. Phillips</i>				22. NAME AND ADDRESS OF FACILITY Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland 20904			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Hemorrhagic Shock DUE TO (OR AS A CONSEQUENCE OF): b. Disseminated Intravascular Coagulation DUE TO (OR AS A CONSEQUENCE OF): c. Open Biopsy of the Liver DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death 1 day 1 day 1 day							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hepatocellular Carcinoma							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Spinder Singh MD</i>				29c. LICENSE NUMBER MD45560		29d. DATE SIGNED (Month, Day, Year) April 14, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Spinder Singh, M.D., 3060 Mitchellville Rd. Bowie, MD 20716							
31. DATE FILED (Month, Day, Year) APR 21 1995				32. REGISTRAR'S SIGNATURE <i>John A. Hatcher</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13825

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) SANDRA Kay NEAL				2. DATE OF DEATH MONTH APRIL DAY 20 YEAR 1995		3. TIME OF DEATH 11:10A M	
4. SOCIAL SECURITY NUMBER 219-66-2024		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 38 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 19, 1956	
8. BIRTHPLACE (State or Foreign Country) Germany				9a. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY	
9c. COUNTY OF DEATH Baltimore				10a. STATE Maryland		10b. COUNTY Washington	
10c. CITY, TOWN OR LOCATION Smithsburg				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 14159 Tower Road	
10f. ZIP CODE 21783				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 years College (1-4 or 5+) College				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Owner / Operator		16b. KIND OF BUSINESS/INDUSTRY Restaurant	
17. FATHER'S NAME (First, Middle, Last) Derward E. Davis				18. MOTHER'S NAME (First, Middle, Maiden Surname) Evalena G. Hemrick			
19a. INFORMANT'S NAME (Type/Print) Stanley Robert Neal				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14159 Tower Road Smithsburg, Maryland 21783			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Rose Hill Cemetery 4-25-1995		20c. LOCATION — City or Town, State Hagerstown, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Douglas A. Fiery</i>				22. NAME AND ADDRESS OF FACILITY Douglas A. Fiery Funeral Home 1331 Eastern Blvd. N. Hagerstown, Md. 21742			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Septic Shock DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Autologous bone marrow transplant for breast cancer							
24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Robert Anderson, M.D.</i>				29c. LICENSE NUMBER M6222		29d. DATE SIGNED (Month, Day, Year) 4/20/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ROBYN ANDERSON Tower 110600 N. Wolfe St. Baltimore 21287							
31. DATE FILED (Month, Day, Year) APR 26 1995				32. REGISTRAR'S SIGNATURE <i>John A. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician.

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IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13826

Amended #29d 4/17/95 MRT Montgomery County

FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Helen M O'Neil</i>				2. DATE OF DEATH MONTH DAY YEAR <i>04 12 95</i>		3. TIME OF DEATH <i>12 10 PM</i>	
4. SOCIAL SECURITY NUMBER <i>269-12-0035</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) <i>84</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>1911 March 13,</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Collingswood Nursing Center</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Rockville</i>		9c. COUNTY OF DEATH <i>Montgomery</i>	
10a. STATE <i>Maryland</i>		10b. COUNTY <i>Montgomery</i>		10c. CITY, TOWN OR LOCATION <i>Silver Spring</i>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <i>10110 New Hampshire Avenue</i>				10f. ZIP CODE <i>20903</i>		10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <i>Elementary/Secondary (0-12) 11</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Factory Worker</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Tire and Rubber</i>			
17. FATHER'S NAME (First, Middle, Last) <i>James Hallinan</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Martha Sibert</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Ellen O. Woods</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>907 Langley Drive Silver Spring, Maryland 20901</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Gate of Heaven Cemetery 4/14/95</i>		20c. LOCATION — City or Town, State <i>Silver Spring, Maryland</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Steven J. Stoud</i>				22. NAME AND ADDRESS OF FACILITY <i>Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Sil. Spr., MD 20901</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>congestive heart failure</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>rheumatoid & arterio-sclerotic heart disease</i> DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death <i>days</i> <i>years</i>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>severe esophageal atresia, malrotation</i>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Wilfred R. Ehrmantraut MD</i>				29c. LICENSE NUMBER <i>D00946</i>		29d. DATE SIGNED (Month, Day, Year) <i>4/12/95</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Wilfred R. Ehrmantraut, M.D. 11125 Rockville Pike #103, Rockville, MD 20852</i>							
31. DATE FILED (Month, Day, Year) <i>APR 17 1995</i>				32. REGISTRAR'S SIGNATURE <i>John S. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95-2468-015

DWG

ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-723 5/19/95 t.t

95 13827

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) DAVID CHRISTOPHER OSBORNE				2. DATE OF DEATH MONTH APRIL DAY 27 YEAR 95		3. TIME OF DEATH 0846A M	
4. SOCIAL SECURITY NUMBER 212-80-1810		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 26 YRS.		7. DATE OF BIRTH (Month, Day, Year) Aug. 6, 1968	
9a. FACILITY NAME (If not institution, give street and number) 253 BRIDGE STREET				9b. CITY, TOWN OR LOCATION OF DEATH ELKTON		9c. COUNTY OF DEATH CECIL	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Cecil		10c. CITY, TOWN OR LOCATION Elkton		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 136 McCleary Road				10f. ZIP CODE 21921		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Maintenance Apprentice		16b. KIND OF BUSINESS/INDUSTRY Industrial			
17. FATHER'S NAME (First, Middle, Last) Roger Donald Osborne				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Ann Brooks			
19a. INFORMANT'S NAME (Type/Print) Mary Ann Baker				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 136 McCleary Road - Elkton, MD 21921			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) R.A. Ferris & Company		DATE 4-29		20c. LOCATION — City or Town, State West Chester, PA	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Dennis J. Chute</i>				22. NAME AND ADDRESS OF FACILITY Hicks Home for Funerals, P.A. 103 West Stockton Street Elkton, MD 21921-5521			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ACUTE NARCOTIC INTOXICATION DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input checked="" type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) FOUND 4-27-95		28b. TIME OF INJURY 8:00 A		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED UNKNOWN		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) FOUND AT HOME			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 253 BRIDGE ST. ELKTON, MARYLAND					
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dennis J. Chute</i>				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) APRIL 27/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 111 PENN STREET, BALTIMORE, MARYLAND 21201							
31. DATE FILED (Month, Day, Year) MAY 03 1995		32. REGISTRAR'S SIGNATURE <i>John D. ...</i>					

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

ITEMS: 23 PART I, 27, PER MEO FILM G-723 5/30/95 t.t

95-13828

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) SHAUNA LYNNE OSBOURNE				2. DATE OF DEATH MONTH DAY YEAR APRIL 20, 1995		3. TIME OF DEATH 8:17 a.m.				
4. SOCIAL SECURITY NUMBER 212-86-5669		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 22 YRS.		7. DATE OF BIRTH (Month, Day, Year) Oct 10, 1972		8. BIRTHPLACE (State or Foreign Country) PA		
9a. FACILITY NAME (If not institution, give street and number) MEMORIAL HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH ALLEGANY			9c. COUNTY OF DEATH CUMBERLAND			
10a. STATE MD		10b. COUNTY Allegany		10c. CITY, TOWN OR LOCATION Cumberland			10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER 5C Fort Cumberland Homes				10f. ZIP CODE 21502		10g. CITIZEN OF WHAT COUNTRY? USA				
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Sales Clerk		16b. KIND OF BUSINESS/INDUSTRY Retail Dept. Store						
17. FATHER'S NAME (First, Middle, Last) Norman L. Osbourne, Jr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Peggy Ann (Dyche)						
19a. INFORMANT'S NAME (Type/Print) Peggy A. Osbourne				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 224 Baltimore Avenue; Cumberland, MD 21502						
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Sunset Memorial Park		DATE 04/24		20c. LOCATION — City or Town, State Cumberland, MD				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James F. Scarpelli</i>				22. NAME AND ADDRESS OF FACILITY Scarpelli Funeral Home Cumberland, MD 21502						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CARDIOMYOPATHY OF PREGNANCY DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>										
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. SIGNATURE AND TITLE OF CERTIFIER <i>David R. Fowler</i>				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) APRIL 21, 1995				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) David R. Fowler 111 Penn Street, Baltimore, Maryland 21201										
31. DATE FILED (Month, Day, Year) MAY 01 1995				32. REGISTRAR'S SIGNATURE <i>John Andrew Randall</i>						

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



James J. Thompson

James J. Thompson

95 13829

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) August Joseph Palewick				2. DATE OF DEATH MONTH DAY YEAR April 21, 1995		3. TIME OF DEATH 3:00 AM	
4. SOCIAL SECURITY NUMBER 216-01-4632		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 92 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 18, 1902	
9a. FACILITY NAME (If not institution, give street and number) 903 Long Bar Harbor Rd.				9b. CITY, TOWN OR LOCATION OF DEATH Abingdon		9c. COUNTY OF DEATH Harford	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Harford		10c. CITY, TOWN OR LOCATION Abingdon		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 903 Long Bar Harbor Rd.				10f. ZIP CODE 21009		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Mechanical Engineer		16b. KIND OF BUSINESS/INDUSTRY Manufacturing			
17. FATHER'S NAME (First, Middle, Last) Frederick Vincent Palewick				18. MOTHER'S NAME (First, Middle, Maiden Surname) Antoniana (nm) Stenski			
19a. INFORMANT'S NAME (Type/Print) Mary E. Palewick				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 902 Long Bar Harbor Road, Abingdon, Md. 21009			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Moreland Memorial Park 4/25/95		20c. LOCATION — City or Town, State Baltimore, Maryland		22. NAME AND ADDRESS OF FACILITY McComas Funeral Home 1317 Cokesbury Rd. Abingdon, Md. 21009	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Howard K. [Signature]</i>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>metastatic cancer</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>cardiac disease</i> <i>CHF</i> DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>							Approximate Interval Between Onset and Death 2/5
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>David S. Dunn</i>				29c. LICENSE NUMBER D32299		29d. DATE SIGNED (Month, Day, Year) 4/21/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DAVID S. DUNN 2105 Laurel Bush Rd							
31. DATE FILED (Month, Day, Year) APR 24 1995		32. REGISTRAR'S SIGNATURE <i>John Anderson-Rodall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.


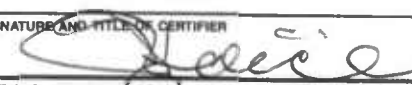
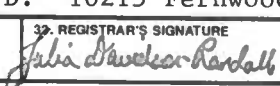
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13830

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Evelyn Patricia Phelan				2. DATE OF DEATH MONTH DAY YEAR April 13, 1995		3. TIME OF DEATH 1:50 A M	
4. SOCIAL SECURITY NUMBER 080-30-2122		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 57 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Feb. 24, 1938	
8. BIRTHPLACE (State or Foreign Country) New York				9a. FACILITY NAME (If not Institution, give street and number) 11711 College View Drive		9b. CITY, TOWN OR LOCATION OF DEATH Wheaton	
9c. COUNTY OF DEATH Montgomery				10a. STATE Maryland		10b. COUNTY Montgomery	
10c. CITY, TOWN OR LOCATION Silver Spring				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 11834 Charles Road	
10f. ZIP CODE 20906				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Account Technician		16b. KIND OF BUSINESS/INDUSTRY Federal Government	
17. FATHER'S NAME (First, Middle, Last) William Michael Phelan				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Catherine Rohan			
19a. INFORMANT'S NAME (Type/Print) Mary Catherine Roche				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11834 Charles Road Silver Spring, Maryland 20906			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gate of Heaven Cemetery 4/19/95		20c. LOCATION — City or Town, State Silver Spring, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Sil. Spr., MD 20901			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Ovarian Cancer DUE TO (OR AS A CONSEQUENCE OF): b. Hepatic Failure DUE TO (OR AS A CONSEQUENCE OF): c. Partial Bowel Obstruction DUE TO (OR AS A CONSEQUENCE OF): d. Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D29142		29d. DATE SIGNED (Month, Day, Year) April 13, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Charles Boice, M.D. 10215 Fernwood Rd., #303 Bethesda, MD 20817							
31. DATE FILED (Month, Day, Year) APR 17 1995		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13831

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ROBERT DELOS PRESLER				2. DATE OF DEATH MONTH APRIL DAY 15 YEAR 1995		3. TIME OF DEATH 2P M	
4. SOCIAL SECURITY NUMBER 104-12-8034		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 72 YRS.		7. DATE OF BIRTH (Month, Day, Year) April 25, 1922	
8. BIRTHPLACE (State or Foreign Country) New York		9a. FACILITY NAME (If not institution, give street and number) 10922 Pleasant Acres Drive		9b. CITY, TOWN OR LOCATION OF DEATH Adelphi		9c. COUNTY OF DEATH Prince George's	
10a. STATE Maryland		10b. COUNTY Prince George's		10c. CITY, TOWN OR LOCATION Beltsville		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 11372 Cherry Hill Road #102				10f. ZIP CODE 20705		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES USMC, WW II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Accountant		16b. KIND OF BUSINESS/INDUSTRY Public Accounting			
17. FATHER'S NAME (First, Middle, Last) John D. Saunders				18. MOTHER'S NAME (First, Middle, Maiden Surname) Jeanette Presler			
19a. INFORMANT'S NAME (Type/Print) Sally McCash (Daughter)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10922 Pleasant Acres Drive, Adelphi, MD 20783			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Chesapeake Crematory		DATE 4-18		20c. LOCATION — City or Town, State Beltsville, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> MO0827				22. NAME AND ADDRESS OF FACILITY Rapp Funeral Services, P.A. 933 Gist Ave, Silver Spring, MD 20910			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Chronic obstructive pulmonary disease DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>[Signature]</i> ADIPONTY DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) (daughters house)		27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER 21230		29d. DATE SIGNED (Month, Day, Year) April 16/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) August P. Rodriguez MD, 5009 Rayburn Ct. Cp. Sp. Md 20748							
31. DATE FILED (Month, Day, Year) APR 19 1995				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13832

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) EVELYN SARAH PROMISEL				2. DATE OF DEATH MONTH DAY YEAR APRIL 16, 1995		3. TIME OF DEATH 10:15 PM	
4. SOCIAL SECURITY NUMBER 220-34-8793		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 85 YRS. MONTHS DAYS HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) OCT. 15, 1909	
8. BIRTHPLACE (State or Foreign Country) MAINE							
9a. FACILITY NAME (If not institution, give street and number) MANOR CARE				9b. CITY, TOWN OR LOCATION OF DEATH BETHESDA		9c. COUNTY OF DEATH MONTGOMERY	
RESIDENCE OF DECEASED							
10a. STATE MARYLAND		10b. COUNTY MONTGOMERY		10c. CITY, TOWN OR LOCATION CHEVY CHASE		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 8100 CONNECTICUT AVENUE #1406				10f. ZIP CODE 20815		10g. CITIZEN OF WHAT COUNTRY? UNITED STATES	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4				16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) REGISTERED NURSE		16b. KIND OF BUSINESS/INDUSTRY MEDICINE	
17. FATHER'S NAME (First, Middle, Last) LOUIS DAVIDOFF				18. MOTHER'S NAME (First, Middle, Maiden Surname) BAILA GRAY			
19a. INFORMANT'S NAME (Type/Print) NATHAN PROMISEL (HUSBAND)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8100 CONNECTICUT AVE, #1406-CHEVY CHASE, MD. 20815			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) KING DAVID MEMORIAL GARDEN 4/18		20c. LOCATION — City or Town, State FALLS CHURCH, VIRGINIA			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Adeno Carcinoma of Colon DUE TO (OR AS A CONSEQUENCE OF): b. Intestinal Obstruction DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Anemia							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER D55357		29d. DATE SIGNED (Month, Day, Year) APRIL 17, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) LEE JONATHAN MUSER, M.D., 5530 WISCONSIN AVE., #1248, CHEVY CHASE, MD 20815							
31. DATE FILED (Month, Day, Year) APR 18 1995		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13833

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ANTOINETTE				2. DATE OF DEATH MONTH APRIL DAY 13 YEAR 1995				3. TIME OF DEATH 1:15 AM	
4. SOCIAL SECURITY NUMBER 056-52-8931		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 90 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) SEPT. 29, 1904	
8. BIRTHPLACE (State or Foreign Country) HUNGARY				9a. FACILITY NAME (If not Institution, give street and number) MANOR CARE				9b. CITY, TOWN OR LOCATION OF DEATH POTOMAC	
9c. COUNTY OF DEATH MONTGOMERY				10a. STATE MARYLAND				10b. COUNTY MONTGOMERY	
10c. CITY, TOWN OR LOCATION CHEVY CHASE				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 8100 CONNECTICUT AVE. #1020	
10f. ZIP CODE 20815				10g. CITIZEN OF WHAT COUNTRY? UNITED STATES				11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER				16b. KIND OF BUSINESS/INDUSTRY OWN HOME	
17. FATHER'S NAME (First, Middle, Last) ARMIN SCHWARTZ				18. MOTHER'S NAME (First, Middle, Maiden Surname) NETTIE KLEIN				19a. INFORMANT'S NAME (Type/Print) STEPHANIE WEISBROTH (DAUGHTER)	
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) HC-75 BOX 1723 LOCUST GROVE, VIRGINIA 22508				20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of place, date) NEW MONTPELIER CEMETERY 4/17	
20c. LOCATION — City or Town, State PINELAWN, NEW YORK				21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Harry M. Giese</i>				22. NAME AND ADDRESS OF FACILITY DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE-ROCKVILLE, MD. 20852	
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Transitional Cell Carcinoma Colitis Anemia, Iron Deficiency Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST				Approximate Interval Between Onset and Death months months months				PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined	
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY M				28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>James A. Green</i>				29c. LICENSE NUMBER 440216	
29d. DATE SIGNED (Month, Day, Year) APRIL 13, 1995				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 5530 WISC. AVE., Chevy Chase, MD 20815				31. DATE FILED (Month, Day, Year) APR 18 1995	
32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.


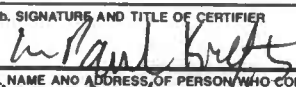
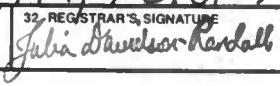
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13834

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Igor Prissoovsky				2. DATE OF DEATH MONTH April DAY 13 YEAR 1995				3. TIME OF DEATH 5:00P M	
4. SOCIAL SECURITY NUMBER 521-48-1608		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 81 YRS.		7. DATE OF BIRTH (Month, Day, Year) Oct. 15 1913		8. BIRTHPLACE (State or Foreign Country) Russia	
9a. FACILITY NAME (If not Institution, give street and number) Holy Cross Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring				9c. COUNTY OF DEATH Montgomery	
RESIDENCE OF DECEDENT									
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Kensington				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 3310 Ferndale Street				10f. ZIP CODE 20895		10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 5+				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Chemist				16b. KIND OF BUSINESS/INDUSTRY National Institutes Health	
17. FATHER'S NAME (First, Middle, Last) Constatine Prissoovsky				18. MOTHER'S NAME (First, Middle, Maiden Surname) Maria Dorofeev					
19a. INFORMANT'S NAME (Type/Print) Natalie Prissoovsky				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3310 Ferndale St. Kensington, Md. 20895					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Holy Trinity Monastery 4/18				20c. LOCATION — City or Town, State Jordanville, New York	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Hines/Rinaldi Funeral Home 11800 New Hampshire Ave. Silver Spring, Md.					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Anoxic Encephalopathy									
b. Cardiac Arrest									
c. Chronic Obstructive Pulmonary Disease									
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED					
28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER 1721435				29d. DATE SIGNED (Month, Day, Year) 4/14/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Paul K. Kretz, 2101 Medical Park N Silver Spring MD 20902									
31. DATE FILED (Month, Day, Year) APR 17 1995				32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

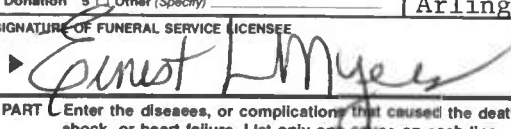

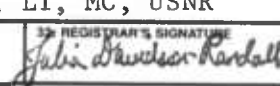
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13835

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) HENRY F. PEACOCK				2. DATE OF DEATH MONTH DAY YEAR APR 18 1995		3. TIME OF DEATH A M 4:55 A	
4. SOCIAL SECURITY NUMBER 230-22-0404		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) YRS. 66		7. DATE OF BIRTH (Month, Day, Year) May 21, 1928	
8. BIRTHPLACE (State or Foreign Country) North Carolina				9a. FACILITY NAME (If not institution, give street and number) NATIONAL NAVAL MEDICAL CENTER		9b. CITY, TOWN OR LOCATION OF DEATH BETHESDA	
9c. COUNTY OF DEATH MONTGOMERY				10a. STATE Virginia		10b. COUNTY Fairfax	
10c. CITY, TOWN OR LOCATION Vienna				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 214 Park Terrace Court # 79	
10f. ZIP CODE 22180				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 5+ College (1-4 or 5+) 5+				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Commander		16b. KIND OF BUSINESS/INDUSTRY U. S. Navy	
17. FATHER'S NAME (First, Middle, Last) Sylvester H. Peacock				18. MOTHER'S NAME (First, Middle, Maiden Surname) Dora M. Neil			
19a. INFORMANT'S NAME (Type/Print) Joyce D. Dyson				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9929 Lindel Lane, Vienna, Va. 22181			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Arlington National Cemetery 4/27/95 Arlington, Va.		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY MONEY & KING VIENNA FUNERAL HOME, INC. 171 W. Maple Ave., Vienna, Va. 22180			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → DISSECTING AORTIC ANEURYSM DUE TO (OR AS A CONSEQUENCE OF): a. _____ b. _____ c. _____ d. _____ Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____							
24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER 12832 (MS)		29d. DATE SIGNED (Month, Day, Year) 18 Apr 95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) GERALD DENTON, LT, MC, USNR				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600			
31. DATE FILED (Month, Day, Year) APR 20 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13836

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Louis Persh				2. DATE OF DEATH MONTH April DAY 19 YEAR 1995		3. TIME OF DEATH 11:10 A.	
4. SOCIAL SECURITY NUMBER 089-03-7573		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 85 YRS.	7. DATE OF BIRTH MONTH May DAY 5 YEAR 1909		8. BIRTHPLACE (State or Foreign Country) NY	
9a. FACILITY NAME (If not institution, give street and number) Bedford Court Nursing Home				9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring		9c. COUNTY OF DEATH Montgomery	
10a. STATE MD		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Silver Spring		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 3330 N. Leisure World Boulevard				10f. ZIP CODE 20906		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR OATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 5 College (1-4 or 5+) 5		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Statistician		16b. KIND OF BUSINESS/INDUSTRY Government			
17. FATHER'S NAME (First, Middle, Last) Israel Persh				18. MOTHER'S NAME (First, Middle, Maiden Surname) Anna Norwitz			
19a. INFORMANT'S NAME (Type/Print) Mary Persh				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3330 N. Leisure World Blvd. Silver Spring MD20906			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) King David Memorial Gardens		20c. LOCATION — City or Town, State 4-20 Falls Church VA		21. SIGNATURE OF FUNERAL SERVICE LICENSEE 	
22. NAME AND ADDRESS OF FACILITY Edward Sagel Funeral Direction 1091 Rockville Pike Rockville Md 20852		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pneumonia Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. c. d. Approximate interval Between Onset and Death Days					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CVA; Dementia; Glucose intolerance				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER 043202		29d. DATE SIGNED (Month, Day, Year) 4-17-95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) C. Ozanne-Blankford MD 3305 N. Leisure World Blvd Silver Spring MD 20906							
31. DATE FILED (Month, Day, Year) APR 21 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.


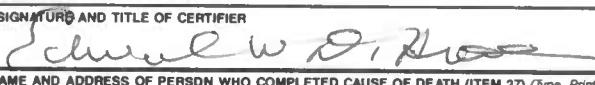

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13837

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Joseph Albert PARKS, Jr.				2. DATE OF DEATH MONTH April DAY 23 YEAR 1995		3. TIME OF DEATH 6:00 AM	
4. SOCIAL SECURITY NUMBER 174-05-0541		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 75 YRS.		7. DATE OF BIRTH (Month, Day, Year) Feb. 6, 1920	
9a. FACILITY NAME (If not institution, give street and number) 842 S. Potomac Street				9b. CITY, TOWN OR LOCATION OF DEATH Hagerstown		9c. COUNTY OF DEATH Washington	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Washington		10c. CITY, TOWN OR LOCATION Hagerstown		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 842 S. Potomac Street				10f. ZIP CODE 21740		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES W.W.II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) 0		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) sheet metal worker		16b. KIND OF BUSINESS/INDUSTRY sand blasting			
17. FATHER'S NAME (First, Middle, Last) Joseph Albert Parks, Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Harriett Louella Long			
19a. INFORMANT'S NAME (Type/Print) Jeffery L. Parks				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13003 Clopper Road, Hagerstown, Md. 21742			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Rest Haven Cemetery 4-26-95		20c. LOCATION — City or Town, State Hagerstown, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Gunshot wound to head DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							Approximate interval Between Onset and Death immediate
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 04/23/95		28b. TIME OF INJURY 6:00AM		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED self inflicted gunshot wound		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) 842 S. Potomac St. Hagerstown			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D01062		29d. DATE SIGNED (Month, Day, Year) 4/24/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Edward W. Ditto, III, M.D. 217 W. Washington St. Hagerstown, MD. 21740							
31. DATE FILED (Month, Day, Year) APR 24 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13038

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Adna Richard PIERCE				2. DATE OF DEATH MONTH DAY YEAR April 17 1995		3. TIME OF DEATH 8:24 a.m. M	
4. SOCIAL SECURITY NUMBER 220-18-1459		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 82 YRS.		7. DATE OF BIRTH (Month, Day, Year) 01-03-1913	
8. BIRTHPLACE (State or Foreign Country) MD.				9a. FACILITY NAME (If not Institution, give street and number) Avalon Manor Home, Inc.		9b. CITY, TOWN OR LOCATION OF DEATH Washington Co., Hagerstown	
9c. COUNTY OF DEATH Washington							
10a. STATE MD.		10b. COUNTY Washington		10c. CITY, TOWN OR LOCATION Big Pool,		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 11544 Big Pool, Road				10f. ZIP CODE 21711		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Guard		16b. KIND OF BUSINESS/INDUSTRY Security Company	
17. FATHER'S NAME (First, Middle, Last) Unknown				18. MOTHER'S NAME (First, Middle, Maiden Surname) Lydia Pierce			
19a. INFORMANT'S NAME (Type/Print) Mildred B. Pierce				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11544 Big Pool Rd. Big Pool, MD. 21711			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Shanktown Cem. 04-19-1995		20c. LOCATION — City or Town, State Big Pool MD.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Craig H. Odum</i>				22. NAME AND ADDRESS OF FACILITY Thompson Funeral Home, Inc. P.O. Box 310 Clear Spring, MD. 21722			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute Subacute Pneumonia Due to (or as a consequence of): b. Chronic obstructive Pulmonary Disease Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 2-3 hrs Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Anterograde Cardiac Arrest Chronic obstructive Pulmonary Disease Multiple Aneurysms with the Risk of Rupture							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide 4 <input type="checkbox"/>		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER 018017		29d. DATE SIGNED (Month, Day, Year) April 17 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) VASANT DATTA, MD 334 MILL ST HAGERSTOWN MD 21740							
31. DATE FILED (Month, Day, Year) APR 18 1995		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.


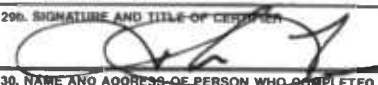
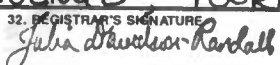
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13839

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Charles Raymond Palmer				2. DATE OF DEATH MONTH DAY YEAR April 13 1995		3. TIME OF DEATH 12:28 a.m.	
4. SOCIAL SECURITY NUMBER 215-24-0431		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 66 YRS.		7. DATE OF BIRTH (Month, Day, Year) December 31 1928	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) 104 Beech Street		9b. CITY, TOWN OR LOCATION OF DEATH North East	
9c. COUNTY OF DEATH Cecil				10a. STATE Maryland		10b. COUNTY Cecil	
10c. CITY, TOWN OR LOCATION North East				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 4 Church Point Road	
10f. ZIP CODE 21901				10g. CITIZEN OF WHAT COUNTRY? United States		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES USMC Korea				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 6+) 6				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Recreational Boat Painter		16b. KIND OF BUSINESS/INDUSTRY Recreational Boat Storage & Repair Firm	
17. FATHER'S NAME (First, Middle, Last) Charles Daniel Palmer				18. MOTHER'S NAME (First, Middle, Maiden Surname) Bertha Heverin			
19a. INFORMANT'S NAME (Type/Print) Charles R. Palmer, II				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 104 Beech Street, North East, MD 21901			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) North East Methodist Cem. 4/15		20c. LOCATION — City or Town, State North East, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Crouch Funeral Home 127 South Main Street, North East MD 21901			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Metastatic CA</u> DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D 32395		29d. DATE SIGNED (Month, Day, Year) 4-13-95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 3 MAULBEN AVENUE, NORTH EAST MD 21901							
31. DATE FILED (Month, Day, Year) APR 14 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

8x1 VA

95 13840

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JUNIE Guthrie Queen				2. DATE OF DEATH MONTH April DAY 19 YEAR 1995		3. TIME OF DEATH 40 22p M	
4. SOCIAL SECURITY NUMBER 255-03-0929		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 84 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 30, 1910	
9a. FACILITY NAME (If not institution, give street and number) Brevin Nursing Home				9b. CITY, TOWN OR LOCATION OF DEATH Havre de Grace		9c. COUNTY OF DEATH Harford	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Harford		10c. CITY, TOWN OR LOCATION Aberdeen		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 35 Hillman Court				10f. ZIP CODE 21001		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 0		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Sewing Machine Operator		16b. KIND OF BUSINESS/INDUSTRY Manufacturing			
17. FATHER'S NAME (First, Middle, Last) William George Guthrie				18. MOTHER'S NAME (First, Middle, Maiden Surname) Annie Bell Speaks			
19a. INFORMANT'S NAME (Type/Print) Mr. Jerry Queen				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 35 Hillman Ct., Aberdeen, Maryland 21001			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Hillview Memorial Park 4/25		20c. LOCATION — City or Town, State Alexander City, Ala.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Gary R. Di Giovanni				22. NAME AND ADDRESS OF FACILITY Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Acute myocardial Infarction Approximate Interval Between Onset and Death 1 hr Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER William MD				29c. LICENSE NUMBER D32809		29d. DATE SIGNED (Month, Day, Year) 4/20/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Kamardin Matham MD 703 Revolution St Havre De Grace MD 21078							
31. DATE FILED (Month, Day, Year) APR 21 1995				32. REGISTRAR'S SIGNATURE John Shuckor-Rodell			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL DR. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.


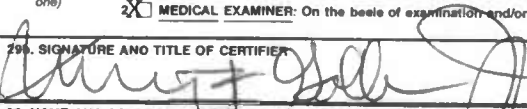
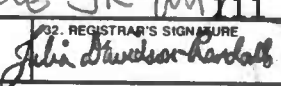
95-2280-023

blh

95 13841

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Matthew Sean Riley				2. DATE OF DEATH MONTH DAY YEAR April 18 1995		3. TIME OF DEATH 0437 M	
4. SOCIAL SECURITY NUMBER 216-94-3179		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 22 YRS.		7. DATE OF BIRTH (Month, Day, Year) NOV 17, 1972	
9a. FACILITY NAME (If not institution, give street and number) Garrett County Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Oakland		9c. COUNTY OF DEATH Garrett	
10a. STATE MARYLAND		10b. COUNTY GARRETT		10c. CITY, TOWN OR LOCATION SWANTON		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 222 TURKEY NECK ROAD				10f. ZIP CODE 21561		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) APPRENTICE ELECTRICIAN		16b. KIND OF BUSINESS/INDUSTRY ELECTRICAL			
17. FATHER'S NAME (First, Middle, Last) REESE LEWIS RILEY				18. MOTHER'S NAME (First, Middle, Maiden Surname) BETTY LOU ELLEN HARDESTY			
19a. INFORMANT'S NAME (Type/Print) BETTY RILEY				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 222 TURKEY NECK ROAD SWANTON, MD 21561			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) WHITE CHURCH CEMETERY		DATE 4/21		20c. LOCATION — City or Town, State OAKLAND, MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE  MO0167				22. NAME AND ADDRESS OF FACILITY P.O. BOX 243 DURST FUNERAL HOME - OAKLAND, MD 21550			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. HEAD & NECK INJURIES DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate interval between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying causes given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED COLLISION DRIVER AUTO VS FIXED OBJECT		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) STREET		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) JASPER RILEY RD, OAKLAND MD	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							29c. LICENSE NUMBER O.C.M.E.
29b. SIGNATURE AND TITLE OF CERTIFIER 							29d. DATE SIGNED (Month, Day, Year) April 18 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARIO F. GOLIE JR MD 111 Penn Street, Baltimore, Maryland 21201							
31. DATE FILED (Month, Day, Year) APR 20 1995							32. REGISTRAR'S SIGNATURE 

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) HERMINIO RIVERA, SR.				2. DATE OF DEATH MONTH APRIL DAY 12 YEAR 1995		3. TIME OF DEATH 7:10 A M	
4. SOCIAL SECURITY NUMBER 126-22-4781		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 91 YRS.		7. DATE OF BIRTH (Month, Day, Year) April 25, 1903	
8. BIRTHPLACE (State or Foreign Country) Puerto Rico				9a. FACILITY NAME (If not institution, give street and number) 7201 Flower Avenue		9b. CITY, TOWN OR LOCATION OF DEATH Takoma Park	
9c. COUNTY OF DEATH Prince George's				10a. STATE Maryland		10b. COUNTY Prince George's	
10c. CITY, TOWN OR LOCATION Takoma Park				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 7201 Flower Avenue	
10f. ZIP CODE 20912				10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO Specify: Puerto Rican		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Tailor		16b. KIND OF BUSINESS/INDUSTRY Clothing / Alterations			
17. FATHER'S NAME (First, Middle, Last) Policarpio Rosa Rivera				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ana Maria Ruiz			
19a. INFORMANT'S NAME (Type/Print) Benjamin Rivera, Sr. (Son)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 813 Forston Street, Takoma Park, MD 20912			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gate of Heaven Cemetery		20c. DATE 4-17		20d. LOCATION — City or Town, State Silver Spring, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE MO0827				22. NAME AND ADDRESS OF FACILITY Rapp Funeral Services, P.A. 933 Gist Ave, Silver Spring, MD 20910			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Smoke inhalation and thermal injuries DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 4-12-95		28b. TIME OF INJURY 2:10 A M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED Victim of house fire				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) Residence			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 7201 Flower Ave, Takoma Park, MD				29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) April 14, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) David R. Fowler, M.D. 111 Penn Street, Baltimore, Maryland 21201							
31. DATE FILED (Month, Day, Year) APR 18 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

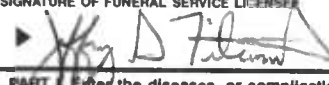

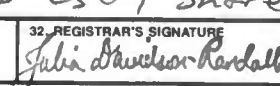
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13843

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) DONALD C. ROYLANCE				2. DATE OF DEATH MONTH APRIL DAY 14 YEAR 1995		3. TIME OF DEATH 6:15 AM	
4. SOCIAL SECURITY NUMBER 212 14 5848		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 74 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 18, 1920	
9a. FACILITY NAME (If not institution, give street and number) Holy Cross Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring		9c. COUNTY OF DEATH Montgomery	
10a. STATE Maryland				10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Potomac	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 12210 Glen Mill Road			
10f. ZIP CODE 20854				10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES World War II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) - College (1-4 or 5+) 4				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Attorney		16b. KIND OF BUSINESS/INDUSTRY Patent	
17. FATHER'S NAME (First, Middle, Last) William G. Roylance				18. MOTHER'S NAME (First, Middle, Maiden Surname) Freda Zender			
19a. INFORMANT'S NAME (Type/Print) Mary Lou Roylance				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12210 Glen Mill Road, Potomac, Maryland 20854			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Montgomery Crematorium, Inc. April 15, 1995		20c. LOCATION — City or Town, State Bethesda, Maryland		22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE  M00689				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Pneumonia DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST Chronic Obstructive Pulmonary Disease DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death 1 wk. 20 yrs.			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cardiovascular disease Diabetes mellitus				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>				25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined			
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D41931		29d. DATE SIGNED (Month, Day, Year) Apr. 14, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) R Shumacher MD 2309 Shorefield Rd. Wheaton, MD 20902							
31. DATE FILED (Month, Day, Year) APR 17 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13844

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Louise S. Roberts				2. DATE OF DEATH MONTH DAY YEAR April 19, 1995				3. TIME OF DEATH 8:00 P			
4. SOCIAL SECURITY NUMBER 391.36.2109		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 58 YRS.		7. DATE OF BIRTH (Month, Day, Year) Feb. 1, 1937		8. BIRTHPLACE (State or Foreign Country) New York			
9a. FACILITY NAME (If not institution, give street and number) 7105 Meadow Lane				9b. CITY, TOWN OR LOCATION OF DEATH Chevy Chase				9c. COUNTY OF DEATH Montgomery			
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Chevy Chase				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 7105 Meadow Lane				10f. ZIP CODE 20815		10g. CITIZEN OF WHAT COUNTRY? U.S.A.					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) +4 College (1-4 or 5+) +4		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Landscape Designer				16b. KIND OF BUSINESS/INDUSTRY Designer					
17. FATHER'S NAME (First, Middle, Last) Charles L. Stover				18. MOTHER'S NAME (First, Middle, Maiden Surname) Margaret Milme							
19a. INFORMANT'S NAME (Type/Print) John T. Roberts				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7105 Meadow Lane Chevy Chase, Md. 20815							
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Mt. Comfort Crematory		DATE 4/20		20c. LOCATION — City or Town, State Alexandria, Va.					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Loah M. Peters</i>				22. NAME AND ADDRESS OF FACILITY Joseph Gawler's Sons 5130 WI AVE NW WASHINGTON DC 20016							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. METASTATIC BREAST CANCER DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. c. d. Approximate interval Between Onset and Death 3 1/2 years											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Frederick Barr M.D.</i>				29c. LICENSE NUMBER D22775		29d. DATE SIGNED (Month, Day, Year) 04/20/1995					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Frederick Barr, M.D. 5454 Wisconsin Ave. Chevy Chase, Md.											
31. DATE FILED (Month, Day, Year) APR 21 1995				32. REGISTRAR'S SIGNATURE <i>John D. Anderson</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13845

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Rose Ann Ripley				2. DATE OF DEATH MONTH DAY YEAR April 19, 1995		3. TIME OF DEATH 12:20 A M	
4. SOCIAL SECURITY NUMBER 217-28-8063		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 92 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Apr. 20, 1902	
8. BIRTHPLACE (State or Foreign Country) Scotland				9a. FACILITY NAME (If not institution, give street and number) Medlantic Manor Layhill		9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring	
9c. COUNTY OF DEATH Montgomery				10a. STATE Maryland		10b. COUNTY Montgomery	
10c. CITY, TOWN OR LOCATION Silver Spring				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 14804 Harold Road	
10f. ZIP CODE 20905				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: White				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 5 College (1-4 or 5+) 5			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker				16b. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) Unknown				18. MOTHER'S NAME (First, Middle, Maiden Surname) Unknown			
19a. INFORMANT'S NAME (Type/Print) Walter R. Ripley				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14804 Harold Road, Silver Spring, Maryland 20905			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Fort Lincoln Cemetery 4/21		20c. LOCATION — City or Town, State Brentwood, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James J. Ripley</i>				22. NAME AND ADDRESS OF FACILITY Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland 20904			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Congestive Heart Failure DUE TO (OR AS A CONSEQUENCE OF): b. Coronary Artery Disease DUE TO (OR AS A CONSEQUENCE OF): c. Cerebrovascular Accident DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death 4 years 10 years 3 years							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>W. J. Ripley</i>				29c. LICENSE NUMBER D32817		29d. DATE SIGNED (Month, Day, Year) April 19, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) M. Wajeed Khan, M.D., 12016 Georgia Avenue, Wheaton, Maryland 20902-2004							
31. DATE FILED (Month, Day, Year) APR 21 1995				32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.




95-2151-031
CIP

95 13846

ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-723 5/12/95 t.t

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) PATRICK L. REDMER				2. DATE OF DEATH MONTH DAY YEAR 04 13 1995		3. TIME OF DEATH 5:59 PM			
4. SOCIAL SECURITY NUMBER 214-43-4604		5. SEX 1 M 2 F		6. AGE (In yrs. last birthday) YRS. MONTHS DAYS 5 5 5		7. DATE OF BIRTH (Month, Day, Year) Nov. 8, 1994		8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not Institution, give street and number) HOLY CROSS HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH SILVER SPRING			9c. COUNTY OF DEATH MONTGOMERY		
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Silver Spring			10d. INSIDE CITY LIMITS? 1 YES 2 NO		
10e. STREET AND NUMBER 14901 Lady Meade Circle				10f. ZIP CODE 20906		10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) N/A College (1-4 or 5+) N/A		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) N/A			16b. KIND OF BUSINESS/INDUSTRY				
17. FATHER'S NAME (First, Middle, Last) David Milton Redmer				18. MOTHER'S NAME (First, Middle, Maiden Surname) Loretta Marie Spigler					
19a. INFORMANT'S NAME (Type/Print) David M. Redmer				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14901 Lady Meade Circle, Silver Spring, Maryland 20906					
20a. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gate of Heaven Cemetery 4/18		OATE		20c. LOCATION — City or Town, State Silver Spring, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland 20904					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → POSITIONAL ASPHYXIA Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify)							
27. MANNER OF DEATH 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined		28a. DATE OF INJURY (Month, Day, Year) 4-13-95		28b. TIME OF INJURY 4:50 PM		28c. INJURY AT WORK? 1 YES 2 NO		28d. DESCRIBE HOW INJURY OCCURRED SUBJECT FELL OFF BED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) HOME				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 14901 LADYMEADE CIRCLE SILVER SPRING, MARYLAND					
29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) APRIL 14, 1995			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201									
31. DATE FILED (Month, Day, Year) APR 21 1995		32. REGISTRAR'S SIGNATURE 							

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

95 13847

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Manuel f. Reider				2. DATE OF DEATH MONTH April DAY 19 YEAR 1995		3. TIME OF DEATH 7:00 a^m	
4. SOCIAL SECURITY NUMBER 294-09-1777		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 75 YRS.		7. DATE OF BIRTH (Month, Day, Year) 10-26-1919	
8. BIRTHPLACE (State or Foreign Country) Ohio				9a. FACILITY NAME (If not institution, give street and number) Washington Adventist Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Takoma Park	
9c. COUNTY OF DEATH Montgomery				10a. STATE Md.		10b. COUNTY Montgomery	
10c. CITY, TOWN OR LOCATION Silver Spring				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 15107 Interlachen Dr.	
10f. ZIP CODE 20906				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: White				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Baker				16b. KIND OF BUSINESS/INDUSTRY Food/Baking			
17. FATHER'S NAME (First, Middle, Last) Meyer Reider				18. MOTHER'S NAME (First, Middle, Maiden Surname) Sarah Wolf			
19a. INFORMANT'S NAME (Type/Print) Jeffrey Reider				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6710 Greentree Rd. Bethesda, Md. 20817			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Judean Memorial Garden 4/20			
20c. LOCATION — City or Town, State Olney, Md.				21. SIGNATURE OF FUNERAL SERVICE LICENSEE 			
22. NAME AND ADDRESS OF FACILITY Edward Sagel Funeral Direction 1091 Rockville Pike Rockville Md 20852				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → RENAL FAILURE DUE TO (OR AS A CONSEQUENCE OF): DIABETIC NEPHROSCLEROSIS Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST Severe Coronary Artery Disease with Consecutive Heart Failure DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>			
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year) 4/19/95			
28b. TIME OF INJURY M				28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER 005568			
29d. DATE SIGNED (Month, Day, Year) 4/19/95				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SAMUEL ITSCOFF, M.D. 10313 GEORGIA AVE. SILVER SPRING, MD 20902			
31. DATE FILED (Month, Day, Year) APR 21 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13848

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Mary Evelyn Reeder				2. DATE OF DEATH MONTH DAY YEAR 4 16 95		3. TIME OF DEATH 11:25 AM	
4. SOCIAL SECURITY NUMBER 234-80-6480		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 72 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Aug. 20, 1922	
8. BIRTHPLACE (State or Foreign Country) W. Va.				9a. FACILITY NAME (If not institution, give street and number) Washington County Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Hagerstown	
10a. STATE Maryland		10b. COUNTY Washington		10c. CITY, TOWN OR LOCATION Hagerstown		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 16315 McGregor Drive				10f. ZIP CODE 21740		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife		16b. KIND OF BUSINESS/INDUSTRY Homemaker			
17. FATHER'S NAME (First, Middle, Last) Leonard Treadway				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mabel Flora Waldron			
19a. INFORMANT'S NAME (Type/Print) Patricia C. Grams				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 691 - Sharpsburg, MD 21782			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Brownsville Heights Cemetery 4/19		20c. LOCATION — City or Town, State Brownsville, MD		21. SIGNATURE OF FUNERAL SERVICE LICENSEE Robert L. Spencer	
22. NAME AND ADDRESS OF FACILITY Eackles-Spencer Funeral Home Harpers Ferry, WV 25425		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Respiratory Failure DUE TO (OR AS A CONSEQUENCE OF): Pneumonia DUE TO (OR AS A CONSEQUENCE OF): Chronic Lung Disease DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death Minutes Days Years					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide 4 <input type="checkbox"/>		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER Martin W. Galt APR 17 1995				29c. LICENSE NUMBER D31880		29d. DATE SIGNED (Month, Day, Year) 4/16/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Martin W. Galt, Registrar, 1110 Medical Campus Rd Hagerstown, MD 21740							
31. SIGNATURE OF REGISTRAR John H. ...							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.


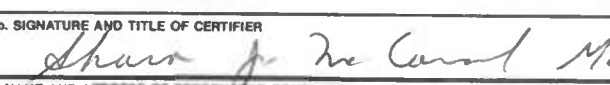
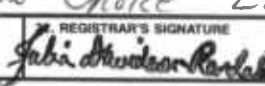
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13849

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Grace Brierley Rauscher				2. DATE OF DEATH MONTH APRIL DAY 18 YEAR 95		3. TIME OF DEATH 10:40 A M	
4. SOCIAL SECURITY NUMBER 218-16-1118		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 88 YRS.		7. DATE OF BIRTH (Month, Day, Year) 07-05-1906	
8. BIRTHPLACE (State or Foreign Country) MD				9a. FACILITY NAME (If not institution, give street and number) St. Agnes Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore	
9c. COUNTY OF DEATH							
RESIDENCE OF DECEDENT							
10a. STATE MD		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Catonsville		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 709 Maiden Choice Lane				10f. ZIP CODE 21228		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) 				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Home	
17. FATHER'S NAME (First, Middle, Last) Arthur Foster				18. MOTHER'S NAME (First, Middle, Maiden Surname) Alexina Brierley			
19a. INFORMANT'S NAME (Type/Print) Mrs. Grace A. Carter				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9304 Orbitan Road, Baltimore, MD 21234			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Angel Hill Cemetery		DATE 4/21		20c. LOCATION — City or Town, State Havre de Grace, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSE 				22. NAME AND ADDRESS OF FACILITY Mitchell-Smith Funeral Home, P.A. Havre de Grace, MD 21078-3197			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Intracranial Bleed							
DUE TO (OR AS A CONSEQUENCE OF):							
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
DUE TO (OR AS A CONSEQUENCE OF):							
DUE TO (OR AS A CONSEQUENCE OF):							
DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D38762		29d. DATE SIGNED (Month, Day, Year) 4/18/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 717 Maiden Choice Lane Balt., Md. 21228							
31. DATE FILED (Month, Day, Year) APR 21 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020



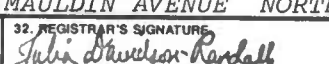
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13850

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) LEON DOUGLAS ROEMER				2. DATE OF DEATH MONTH APRIL DAY 13 YEAR 1995				3. TIME OF DEATH 6:50AM							
4. SOCIAL SECURITY NUMBER 222-07-6155		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 80 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) JULY 4, 1914		8. BIRTHPLACE (State or Foreign Country) Delaware			
9a. FACILITY NAME (If not institution, give street and number) LAURELWOOD NURSING CENTER						9b. CITY, TOWN OR LOCATION OF DEATH ELKTON, MARYLAND				9c. COUNTY OF DEATH CECIL					
RESIDENCE OF DECEASED															
10a. STATE Maryland		10b. COUNTY Cecil		10c. CITY, TOWN OR LOCATION North East				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
10e. STREET AND NUMBER 110 Wallace Avenue						10f. ZIP CODE 21901				10g. CITIZEN OF WHAT COUNTRY? United States					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES US Army WWII				13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4				15a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Supervisor Drafting Department				15b. KIND OF BUSINESS/INDUSTRY Gunpowder Manufacturing							
17. FATHER'S NAME (First, Middle, Last) Joseph Roemer						18. MOTHER'S NAME (First, Middle, Maiden Surname) Florence (Maiden Name Unknown)									
19a. INFORMANT'S NAME (Type/Print) John A. Manning, Jr.						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 691 Hances Point Road, North East, MD 21901									
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Delaware Veterans Cemetery 4/17				DATE		20c. LOCATION — City or Town, State Bear, Delaware					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 						22. NAME AND ADDRESS OF FACILITY Crouch Funeral Home 127 South Main Street, North East, MD 21901									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Septic Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. Core bronschial Disease DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death															
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.															
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>												24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
29a. SIGNATURE AND TITLE OF CERTIFIER 						29c. LICENSE NUMBER D32395				29d. DATE SIGNED (Month, Day, Year) 4-13-95					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) THOMAS FINUCAN 3 MAULDIN AVENUE NORTH EAST, MARYLAND 21901															
31. DATE FILED (Month, Day, Year) APR 14 1995				32. REGISTRAR'S SIGNATURE 											

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

12 x 1 UA

95 13851

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Melva Marie Rice				2. DATE OF DEATH MONTH 4 DAY 13 YEAR 95				3. TIME OF DEATH 118 P M											
4. SOCIAL SECURITY NUMBER 213-30-1252				5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 62 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS. HOURS 0 MIN. 0		7. DATE OF BIRTH (Month, Day, Year) May 26 1932		8. BIRTHPLACE (State or Foreign Country) Maryland					
9a. FACILITY NAME (If not institution, give street and number) Carroll County General Hospital								9b. CITY, TOWN OR LOCATION OF DEATH Westminster				9c. COUNTY OF DEATH Carroll							
10a. STATE Maryland				10b. COUNTY Carroll				10c. CITY, TOWN OR LOCATION Westminster				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER 134 Smith Avenue								10f. ZIP CODE 21157				10g. CITIZEN OF WHAT COUNTRY? United States							
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: white							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College								16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker				16b. KIND OF BUSINESS/INDUSTRY n/a							
17. FATHER'S NAME (First, Middle, Last) William Perry								18. MOTHER'S NAME (First, Middle, Maiden Surname) Mavis Marie Forrest											
19a. INFORMANT'S NAME (Type/Print) Stanley Curtis Rice								19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 134 Smith Road, Westminster, MD 21157											
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Deer Park Cemetery 4/17/95				20c. LOCATION — City or Town, State Westminster, MD											
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Katherine Linds-Sweitzer								22. NAME AND ADDRESS OF FACILITY Pritts Funeral Home & Chapel 412 Washington Rd., Westminster, MD											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Electromechanical Dissociation DUE TO (OR AS A CONSEQUENCE OF): b. Respiratory Arrest DUE TO (OR AS A CONSEQUENCE OF): c. Brain Death DUE TO (OR AS A CONSEQUENCE OF): d. Cardiac Arrest Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST												Approximate interval Between Onset and Death 40 min 26 hrs 26 hrs 26 hrs							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>																			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)															
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED							
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)								28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)											
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																			
29b. SIGNATURE AND TITLE OF CERTIFIER Robert Dinkels								29c. LICENSE NUMBER D39296				29d. DATE SIGNED (Month, Day, Year) 4/13/95							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) R. Ricketts MD Westminster MD 21157																			
31. DATE FILED (Month, Day, Year) APR 17 1995				32. REGISTRAR'S SIGNATURE John Decker-Randall															

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13852

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) William Chester Sherwood				2. DATE OF DEATH MONTH 04 DAY 23 YEAR 1995		3. TIME OF DEATH 18:30 p.m.	
4. SOCIAL SECURITY NUMBER 236-12-3988		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 81 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 4, 1913	
9a. FACILITY NAME (If not institution, give street and number) Garrett County Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Oakland		9c. COUNTY OF DEATH Garrett			
RESIDENCE OF DECEDENT							
10a. STATE MD		10b. COUNTY Garrett		10c. CITY, TOWN OR LOCATION Oakland		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 7th & Alder Street				10f. ZIP CODE 21550		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (13-16 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Car Painter		16b. KIND OF BUSINESS/INDUSTRY General Motors			
17. FATHER'S NAME (First, Middle, Last) William Sherwood				18. MOTHER'S NAME (First, Middle, Maiden Surname) Emma Taylor			
19a. INFORMANT'S NAME (Type/Print) Vera Sherwood				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shallmar Road, Kitzmiller, MD 21538			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) 100F Cemetery Apr 26, 1995		20c. LOCATION — City or Town, State Elk Garden, WV			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE David A. Burdock				22. NAME AND ADDRESS OF FACILITY David A. Burdock Funeral Home P.O. Box 523, Kitzmiller, MD 21538			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>pneumonia</u> DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. <u>coronary artery disease</u> DUE TO (OR AS A CONSEQUENCE OF): c. <u>Dementia</u> DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death 2 wks years years							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURRED		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Paul Daniel Miller				29c. LICENSE NUMBER H26154		29d. DATE SIGNED (Month, Day, Year) 4/24/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) P. Daniel Miller 2255 Rt. 135, Mt. Lake Park, MD							
31. DATE FILED (Month, Day, Year) APR 24 1995				32. REGISTRAR'S SIGNATURE John A. Hudson			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.



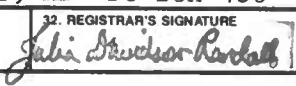
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13853

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) Laura Leedare SHANHOLTZ				2. DATE OF DEATH MONTH DAY YEAR April 18, 1995		3. TIME OF DEATH 7:30 P M	
4. SOCIAL SECURITY NUMBER 220-07-6471		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 79 YRS.		7. DATE OF BIRTH (Month, Day, Year) Apr. 4, 1916	
8. BIRTHPLACE (State or Foreign Country) West Virginia				9a. FACILITY NAME (If not institution, give street and number) Garrett County Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Oakland	
9c. COUNTY OF DEATH Garrett				10a. STATE WV		10b. COUNTY Preston	
10c. CITY, TOWN OR LOCATION Terra Alta				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER HC 82, Box 114	
10f. ZIP CODE 26764				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+) 12				16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Secretary		16b. KIND OF BUSINESS/INDUSTRY Insurance Agency	
17. FATHER'S NAME (First, Middle, Last) Robert L. Lanham				18. MOTHER'S NAME (First, Middle, Maiden Surname) Edith Jane Webb			
19a. INFORMANT'S NAME (Type/Print) Dorothy J. Twigg				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) HC 82, Box 114, Terra Alta, West Virginia 26764			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Omega Crematory		20c. LOCATION — City or Town, State 4/20 Morgantown, WV	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Stewart Funeral Home 32 S. Second St., Oakland, MD 21550			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute Renal Failure DUE TO (OR AS A CONSEQUENCE OF): b. Hypotension & Shock DUE TO (OR AS A CONSEQUENCE OF): c. Congestive Heart Failure DUE TO (OR AS A CONSEQUENCE OF): d. Emphysema Approximate Interval Between Onset and Death 48 hours 4 days 2 Years 2 Years							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ABnormal density middle lobe left lung, osteoarthritis Osteoporosis DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D26650		29d. DATE SIGNED (Month, Day, Year) 4/19/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Margaret A. Kaiser, MD PO Box 486 Oakland MD 21550							
31. DATE FILED (Month, Day, Year) APR 21 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13854

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last) Julia Jane SHAFFER				2. DATE OF DEATH MONTH DAY YEAR April 16, 1995		3. TIME OF DEATH 1:30 A M	
4. SOCIAL SECURITY NUMBER 220-34-1935		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 87 YRS.		7. DATE OF BIRTH (Month, Day, Year) Aug. 25, 1907	
9a. FACILITY NAME (If not institution, give street and number) Cuppett-Weeks Nursing Home				9b. CITY, TOWN OR LOCATION OF DEATH Oakland		9c. COUNTY OF DEATH Garrett	
RESIDENCE OF DECEDENT							
10a. STATE MD		10b. COUNTY Garrett		10c. CITY, TOWN OR LOCATION Oakland		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 797 Crellin Mine Road				10f. ZIP CODE 21550		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+) 9				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife		16b. KIND OF BUSINESS/INDUSTRY Home	
17. FATHER'S NAME (First, Middle, Last) Charles ----- Lantz				18. MOTHER'S NAME (First, Middle, Maiden Surname) Cora ----- Shaffer			
19a. INFORMANT'S NAME (Type/Print) Charles T. Shaffer				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 215 Fingerboard Road, Oakland, Maryland 21550			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Aurora Cemetery		DATE 4/18		20c. LOCATION — City or Town, State Aurora, West Va.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Buddy A. Shaffer				22. NAME AND ADDRESS OF FACILITY Stewart Funeral Home 32 S. Second St., Oakland, MD 21550			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → s. Aspiration DUE TO (OR AS A CONSEQUENCE OF): Stroke DUE TO (OR AS A CONSEQUENCE OF): Sequently ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST c. DUE TO (OR AS A CONSEQUENCE OF): d.				Approximate Interval Between Onset and Death 5 minutes 3 years	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER Robert M. Coughlin MD				29c. LICENSE NUMBER D33464	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Robert M. Coughlin MD PO Box 8 ESM WV 26716				29d. DATE SIGNED (Month, Day, Year) 4/16/95	
31. DATE FILED (Month, Day, Year) APR 19 1995		32. REGISTRAR'S SIGNATURE Julia Anderson-Randall			


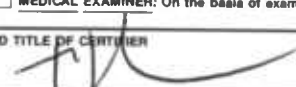

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13855

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Lester William SWEITZER						2. DATE OF DEATH MONTH DAY YEAR April 14, 1995		3. TIME OF DEATH 7:00 P M							
4. SOCIAL SECURITY NUMBER 220-10-1067		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 81 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 12, 1913		8. BIRTHPLACE (State or Foreign Country) Maryland							
9a. FACILITY NAME (If not institution, give street and number) Garrett Co. Memorial Hospital						9b. CITY, TOWN OR LOCATION OF DEATH Oakland		9c. COUNTY OF DEATH Garrett							
RESIDENCE OF DECEDENT															
10a. STATE MD		10b. COUNTY Garrett		10c. CITY, TOWN OR LOCATION Swanton				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER P.O. Box 105				10f. ZIP CODE 21561		10g. CITIZEN OF WHAT COUNTRY? USA									
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White								
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Brakeman			16b. KIND OF BUSINESS/INDUSTRY B&O Railroad								
17. FATHER'S NAME (First, Middle, Last) Truman ----- Sweitzer				18. MOTHER'S NAME (First, Middle, Maiden Surname) Jessie ----- Mosser											
19a. INFORMANT'S NAME (Type/Print) Melvin Sweitzer				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rt. 1, Box 31-A, Swanton, Maryland 21561											
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Georg Cemetery		DATE 4/18		20c. LOCATION — City or Town, State Swanton, Maryland							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Stewart Funeral Home 32 S. Second St., Oakland, MD 21550											
23. PART I. Enter the disease(s) or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cerebrovascular Accident DUE TO (OR AS A CONSEQUENCE OF): b. Hypertension DUE TO (OR AS A CONSEQUENCE OF): c. Diabetes Mellitus DUE TO (OR AS A CONSEQUENCE OF): d. Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST										Approximate Interval Between Onset and Death Immediate Years Years					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER D15333		29d. DATE SIGNED (Month, Day, Year) 4/17/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Thomas Johnson, MD 311 N. Fourth St., Oakland, MD 21550															
31. DATE FILED (Month, Day, Year) APR 19 1995				32. REGISTRAR'S SIGNATURE 											

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95-2197-033

blh

95 13856

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Tyrone Spencer				2. DATE OF DEATH MONTH DAY YEAR April 15 1995		3. TIME OF DEATH M 0002	
4. SOCIAL SECURITY NUMBER 218-02-0740		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 28 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 25, 66	
9a. FACILITY NAME (If not institution, give street and number) Prince Georges Hospital Cntr.				9b. CITY, TOWN OR LOCATION OF DEATH Cheverly		9c. COUNTY OF DEATH Prince Georges	
10a. STATE Maryland		10b. COUNTY Prince George		10c. CITY, TOWN OR LOCATION Upper Marlboro		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 9404 Croom Road				10f. ZIP CODE 20772		10g. CITIZEN OF WHAT COUNTRY? U.S.A	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 12		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Skilled Labor		15b. KIND OF BUSINESS/INDUSTRY GX Air Condition			
17. FATHER'S NAME (First, Middle, Last) Leon E. Spencer				18. MOTHER'S NAME (First, Middle, Maiden Surname) Helen Dorsey			
19a. INFORMANT'S NAME (Type/Print) Sherree Spencer				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9404 Croom Rd, Upper Marlboro MD 20772			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Harmony		20c. LOCATION — City or Town, State 4/21/95 Landover MD		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Lloyd Cole</i>				22. NAME AND ADDRESS OF FACILITY Adams Funeral Home, Aquasco MD 20608			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Stab wounds to chest</i> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) 4/14/95		28b. TIME OF INJURY 2310 M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED Subject stabbed		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) STREET		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 1400 Addison Rd. South	
29. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29a. SIGNATURE AND TITLE OF CERTIFIER <i>John L. Labe MD</i>				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) April 15 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J. Labe MD 111 Penn Street, Baltimore, Maryland 21201							
31. DATE FILED (Month, Day, Year) APR 24 1995				32. REGISTRAR'S SIGNATURE <i>John L. Labe</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13857

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Newton Elmer Six Jr				2. DATE OF DEATH MONTH DAY YEAR April 21 1995		3. TIME OF DEATH 9:44 p M	
4. SOCIAL SECURITY NUMBER 215-14-1705		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 79 YRS.		7. DATE OF BIRTH (Month, Day, Year) NOV. 8, 1915	
8. BIRTHPLACE (State or Foreign Country) MARYLAND				9a. FACILITY NAME (If not institution, give street and number) FREDERICK MEMORIAL HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH FREDERICK	
9c. COUNTY OF DEATH FREDERICK				10a. STATE MARYLAND			
10b. COUNTY CARROLL				10c. CITY, TOWN OR LOCATION MIDDLEBURG			
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 6240 MIDDLEBURG ROAD			
10f. ZIP CODE 21757				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: CAUCASIAN	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11th College (1-4 or 5+) _____		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) PARTS MANAGER		16b. KIND OF BUSINESS/INDUSTRY FARM EQUIPMENT SALES			
17. FATHER'S NAME (First, Middle, Last) NEWTON ELMER SIX, SR.				18. MOTHER'S NAME (First, Middle, Maiden Surname) BERTHA MAE COLLIFLOWER			
19a. INFORMANT'S NAME (Type/Print) RETA M. SIX				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6240 MIDDLEBURG ROAD MIDDLEBURG, MARYLAND 21757			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) _____		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MIDDLEBURG METHODIST CEM. 4/25		20c. LOCATION — City or Town, State MIDDLEBURG, MARYLAND		21. SIGNATURE OF FUNERAL SERVICE LICENSEE P. Kevin Judy	
22. NAME AND ADDRESS OF FACILITY 136 EAST BALTIMORE STREET SKILES FUNERAL HOME TANHEYTOWN, MD 21787		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. RLL Bronchogenic Cancer, Adenocarcinoma DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. _____					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Pulmonary Emboli PERIPHERAL VASC. DISEASE CORONARY ARTERY DISEASE DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO		25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide					
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER James S. Grissom M.D.				29c. LICENSE NUMBER D21944		29d. DATE SIGNED (Month, Day, Year) 4/22/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) James S. GRISSOM 1475 TANBY AVE SUITE 204 FREDERICK, MD							
31. DATE FILED (Month, Day, Year) APR 24 1995				32. REGISTRAR'S SIGNATURE J. Michael Wardell			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13858

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) PETER W. SOLEM				2. DATE OF DEATH MONTH DAY YEAR APRIL 13, 1995		3. TIME OF DEATH 8:30 A.M.	
4. SOCIAL SECURITY NUMBER 579-38-6517		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 89 YRS.		7. DATE OF BIRTH (Month, Day, Year) AUG. 13, 1905	
9a. FACILITY NAME (If not institution, give street and number) 5714 WILSON LANE				9b. CITY, TOWN OR LOCATION OF DEATH BETHESDA		9c. COUNTY OF DEATH MONTGOMERY	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY MONTGOMERY		10c. CITY, TOWN OR LOCATION BETHESDA		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 5714 WILSON LANE				10f. ZIP CODE 20817		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) ATTORNEY		15b. KIND OF BUSINESS/INDUSTRY LAW			
17. FATHER'S NAME (First, Middle, Last) HENRY SOLEM				18. MOTHER'S NAME (First, Middle, Maiden Surname) MARY VOGLAND			
19a. INFORMANT'S NAME (Type/Print) SHERLEE S. NELSON				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 BETHESDA METRO CENTER, BETHESDA, MD. 20814			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) FL. LINCOLN CEM.		20c. DATE 4/18		20d. LOCATION — City or Town, State BRENTWOOD, MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Vernon Simmons</i>				22. NAME AND ADDRESS OF FACILITY JOSEPH GAWLER'S SONS, 5130 WISCONSIN AVE. WASHINGTON, D.C. 20016			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <i>Multi-infarct dementia</i> DUE TO (OR AS A CONSEQUENCE OF):				Approximate Interval Between Onset and Death <i>6 yrs.</i>	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. <i>Hypertension</i> DUE TO (OR AS A CONSEQUENCE OF):				20+	
		c. _____ DUE TO (OR AS A CONSEQUENCE OF):					
		d. _____ DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>osteoporosis</i>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>D. V. Young, Md.</i>		29c. LICENSE NUMBER D.C. 8112	
29d. DATE SIGNED (Month, Day, Year) 4/14/95				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. DAVID V. YOUNG 4530 CONNECTICUT AVE. N.W. WASHINGTON, D.C. 20008			
31. DATE FILED (Month, Day, Year) APR 18 1995				32. REGISTRAR'S SIGNATURE <i>Julia Dawson Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13859

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Anna M. Smith				2. DATE OF DEATH MONTH DAY YEAR April 12, 1995				3. TIME OF DEATH 2:30 A M					
4. SOCIAL SECURITY NUMBER 578-52-2026		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) 101 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) January 26 1894		8. BIRTHPLACE (State or Foreign Country) New York	
9a. FACILITY NAME (If not institution, give street and number) Sacred Heart Home						9b. CITY, TOWN OR LOCATION OF DEATH Hyattsville				9c. COUNTY OF DEATH Prince George's			
RESIDENCE OF DECEDENT													
10a. STATE Maryland		10b. COUNTY Prince George's		10c. CITY, TOWN OR LOCATION Hyattsville				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO					
10e. STREET AND NUMBER 5805 Queens Chapel Road						10f. ZIP CODE 20782		10g. CITIZEN OF WHAT COUNTRY? U.S.A.					
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White					
16. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 12 College (1-4 or 5+) 12				18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Accounting Clerk				16b. KIND OF BUSINESS/INDUSTRY U.S. Government					
17. FATHER'S NAME (First, Middle, Last) Charles W. Smith						16. MOTHER'S NAME (First, Middle, Maiden Surname) Mary T. Slaine							
19a. INFORMANT'S NAME (Type/Print) LELAND SWINDLER						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3221 WYNFORD DR, FAIRFAX, VA 22031							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Mount Olivet Cemetery 4/17				20c. LOCATION — City or Town, State Washington, D.C.					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Reynolds Simmons</i>						22. NAME AND ADDRESS OF FACILITY Joseph Gawler's Sons, Inc. 5130 Wisconsin Avenue, N.W. Washington, D.C. 20016							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Chronic renal failure</u> DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death <u>2 years</u>													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Senile dementia</u>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Peter M. Schissler</i>						29c. LICENSE NUMBER 022780		29d. DATE SIGNED (Month, Day, Year) APRIL 12, 1995					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) PETER M. SCHISLER M.D. 7500 GREENWAY CENTER DRIVE # 430 GREENBELT, MD 20770													
31. DATE FILED (Month, Day, Year) APR 18 1995						32. REGISTRAR'S SIGNATURE <i>Julia Davidson Randall</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13860

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) MARIA SHRAMCHENKO				2. DATE OF DEATH MONTH 4 DAY 7 YEAR 1995		3. TIME OF DEATH 8.03 AM	
4. SOCIAL SECURITY NUMBER 579-44-3648		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 89 YRS.		7. DATE OF BIRTH (Month, Day, Year) January 24, 1906	
8. BIRTHPLACE (State or Foreign Country) Russia				9a. FACILITY NAME (If not institution, give street and number) Holy Cross		9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring	
9c. COUNTY OF DEATH Montgomery				10a. STATE Md		10b. COUNTY Montgomery	
10c. CITY, TOWN OR LOCATION Kensington				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 3000 McComas Ave.	
10f. ZIP CODE 20895				10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Home			
17. FATHER'S NAME (First, Middle, Last) Peter Unknown				18. MOTHER'S NAME (First, Middle, Maiden Surname) Unknown			
19a. INFORMANT'S NAME (Type/Print) Dimitri Lutchenkov				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10805 McComas Ct. Kensington, Md. 20895			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Rock Creek Cemetery 4/10		20c. LOCATION — City or Town, State Washington DC		21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>	
22. NAME AND ADDRESS OF FACILITY Hines/Rinaldi Funeral Home 11800 New Hampshire Ave. Silver Spring, Md.				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Sepsis a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER D43496		29d. DATE SIGNED (Month, Day, Year) APRIL 7, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MOHAMMAD A KHAUD 1299-Lamberton Drive Silver Spring Md 20902							
31. DATE FILED (Month, Day, Year) APR 17 1995				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13861

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) John Denis Sullivan				2. DATE OF DEATH MONTH DAY YEAR April 13, 1995		3. TIME OF DEATH 8:05 A.M. M	
4. SOCIAL SECURITY NUMBER 077-14-4015		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 83 YRS.		7. DATE OF BIRTH (Month, Day, Year) May 6, 1911	
8. BIRTHPLACE (State or Foreign Country) New York		9a. FACILITY NAME (If not institution, give street and number) Holy Cross Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring		9c. COUNTY OF DEATH Montgomery	
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Rockville		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 199 Rollins Avenue #724				10f. ZIP CODE 20852		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II and Korea		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Officer		16b. KIND OF BUSINESS/INDUSTRY Military	
17. FATHER'S NAME (First, Middle, Last) Dennis Joseph Sullivan				18. MOTHER'S NAME (First, Middle, Maiden Surname) Catherine Phalen			
19a. INFORMANT'S NAME (Type/Print) Mary Ann McGarry				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17100 Thorntondale Court Olney, Maryland 20832			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Arlington National Cemetery April 21, 1995		20c. LOCATION — City or Town, State Arlington, Virginia			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Delma J. Lent</i> M00202				22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. SEPSIS b. RENAL FAILURE c. d. Approximate Interval Between Onset and Death MORE THAN 1 WEEK Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — A1 home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Delma J. Lent</i>				29c. LICENSE NUMBER D43496		29d. DATE SIGNED (Month, Day, Year) April 15, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Mohammad Khalid, M.D. 1299 Lamberton Drive Silver Spring, Maryland 20902							
31. DATE FILED (Month, Day, Year) APR 17 1995				32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Amended #7, 4/18/95 MRT Montgomery County 95 13862

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) KAREN LANDERS STONE				2. DATE OF DEATH MONTH April DAY 11 YEAR 1995		3. TIME OF DEATH 2:45 P M	
4. SOCIAL SECURITY NUMBER 037-32-9136		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 48 YRS.	7. DATE OF BIRTH (Month, Day, Year) SEPT. 29, 1946		8. BIRTHPLACE (State or Foreign Country) WASHINGTON, D.C.	
9a. FACILITY NAME (If not institution, give street and number) SUBURBAN HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BETHESDA		9c. COUNTY OF DEATH MONTGOMERY	
10a. STATE MARYLAND		10b. COUNTY MONTGOMERY		10c. CITY, TOWN OR LOCATION CHEVY CHASE		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 3107 CUMMINGS LANE				10f. ZIP CODE 20817		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) ANIMAL CARETAKER		16b. KIND OF BUSINESS/INDUSTRY U.S. GOVERNMENT			
17. FATHER'S NAME (First, Middle, Last) HOWARD LYONS STONE, JR				18. MOTHER'S NAME (First, Middle, Maiden Surname) OLGA COOKE			
19a. INFORMANT'S NAME (Type/Print) OLGA STONE				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3107 CUMMINGS LANE CHEVY CHASE, MD. 20815			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium, or other place) ARLINGTON NATIONAL CEM. 4/21		20c. LOCATION — City or Town, State ARLINGTON, VA.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY JOSEPH GAWLER'S SONS, INC. 20016 5130 WISCONSIN AVE. N.W. WASHINGTON, D.C.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Pneumonia DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death: Days Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Down's Syndrome Normal pressure hydrocephalus DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)				28e. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>Alan S. Chanacez MD</i>			
29c. LICENSE NUMBER 29453				29d. DATE SIGNED (Month, Day, Year) April 11, 1995			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 15115 Shady Grove Rd Rockville MD 20850 ALAN S. CHANACEZ MD							
31. DATE FILED (Month, Day, Year) APR 18 1995				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13863

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last) Shawki Shiblee				2. DATE OF DEATH MONTH 4 DAY 18 YEAR 95		3. TIME OF DEATH 9:30 A M	
4. SOCIAL SECURITY NUMBER 242-50-8506		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 58 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 18, 1936	
8. BIRTHPLACE (State or Foreign Country) Palestine				9a. FACILITY NAME (If not institution, give street and number) Holy Cross Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring	
9c. COUNTY OF DEATH Montgomery				10a. STATE Maryland		10b. COUNTY Montgomery	
10c. CITY, TOWN OR LOCATION Wheaton				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 11505 Taber Street	
10f. ZIP CODE 20902				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: Palestinian				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Deli Clerk				16b. KIND OF BUSINESS/INDUSTRY Retail Food Store			
17. FATHER'S NAME (First, Middle, Last) Shiblee Shiblee				18. MOTHER'S NAME (First, Middle, Maiden Surname) Galileh Saleh			
19a. INFORMANT'S NAME (Type/Print) Victor Shiblee				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11505 Taber Street, Wheaton, Maryland 20902			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gate of Heaven Cemetery 4/21			
20c. LOCATION — City or Town, State Silver Spring, Maryland				21. SIGNATURE OF FUNERAL SERVICE LICENSEE Dani's Rent Holland			
22. NAME AND ADDRESS OF FACILITY Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland 20904				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiomyopathy DUE TO (OR AS A CONSEQUENCE OF): b. Aortic Valve Disease DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER Joel Godwin MD			
29c. LICENSE NUMBER D16495				29d. DATE SIGNED (Month, Day, Year) 4/18/95			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JOEL GODWIN MD 14701 LAUDOLPH RD ROCKVILLE MD 20852				31. DATE FILED (Month, Day, Year) APR 21 1995			
32. REGISTRAR'S SIGNATURE John A. Dwyer							

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 13864

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Jacqueline Frost Sylvester</i>				2. DATE OF DEATH MONTH <i>April</i> DAY <i>19</i> YEAR <i>1995</i>		3. TIME OF DEATH <i>9:15 A M</i>	
4. SOCIAL SECURITY NUMBER <i>031-14-7217</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>69</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>March 19, 1926</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>5402 Huntington Parkway</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Bethesda</i>		9c. COUNTY OF DEATH <i>Montgomery</i>	
RESIDENCE OF DECEDENT							
10a. STATE <i>Maryland</i>		10b. COUNTY <i>Montgomery</i>		10c. CITY, TOWN OR LOCATION <i>Bethesda</i>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <i>5402 Huntington Parkway</i>				10f. ZIP CODE <i>20814</i>		10g. CITIZEN OF WHAT COUNTRY? <i>United States</i>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>—</i> College (1-4 or 8+) <i>2</i>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Nursery School Teacher</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Education</i>	
17. FATHER'S NAME (First, Middle, Last) <i>Ernest Willard Frost</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Ethel Semple</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Robert E. Sylvester</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>5402 Huntington Parkway, Bethesda, MD 20814</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Puritan Lawn Memorial Park April 24, 1995</i>		20c. LOCATION — City or Town, State <i>Peabody, Massachusetts</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Nichele P. Kutta</i> M00348				22. NAME AND ADDRESS OF FACILITY <i>Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave., Bethesda, MD 20814</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>a. arteriosclerotic Heart Disease</i> DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> 4 <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John T. Taylor</i>				29c. LICENSE NUMBER <i>D08540</i>		29d. DATE SIGNED (Month, Day, Year) <i>April 19-95</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>John T. Taylor 8212 Wisconsin Ave Bethesda</i>							
31. DATE FILED (Month, Day, Year) <i>APR 21 1995</i>				32. REGISTRAR'S SIGNATURE <i>John T. Taylor</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

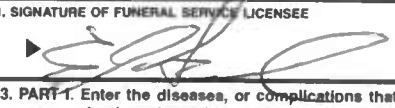
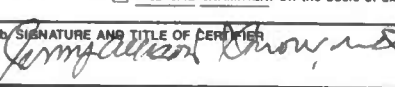

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13865

ITEM: 4. PER F.H. FILM G-732 2/5/96 t.t

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Mary Simmons		2. DATE OF DEATH MONTH DAY YEAR April 18 1995		3. TIME OF DEATH HOURS MIN. SEC. AM/PM 2:30 A. M	
4. SOCIAL SECURITY # 473-10-6050		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (in yrs. last birthday) 80 YRS.	
7. DATE OF BIRTH (Month, Day, Year) July 31 1914		8. BIRTHPLACE (State or Foreign Country) Minnesota		9. FACILITY NAME (If not institution, give street and number) Manor Care Nursing Center	
10a. STATE MD		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Chevy Chase	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 8700 Jones Mill Road		10f. ZIP CODE 20815	
10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+) 2	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Unknown		16b. KIND OF BUSINESS/INDUSTRY Government		17. FATHER'S NAME (First, Middle, Last) Joe Berine	
18. MOTHER'S NAME (First, Middle, Maiden Surname) Bessie Litman		19a. INFORMANT'S NAME (Type/Print) Barbara Drucker		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7111 W. 23rd Street St Louis Park, MINN 55426	
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Mt Lebanon		20c. LOCATION — City or Town, State 4-23 Adelphi MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY Edward Sagel Funeral Direction 1091 Rockville Pike Rockville MD 20852			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Sequently ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.					Approximate interval Between Onset and Death 40025
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. OSTEOARTHRITIS					24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER 4686		29d. DATE SIGNED (Month, Day, Year) 4-18-95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) GERALD ALLISON SNOW, MD 4900 MASSACHUSETTS AVE, N.W. DC 20016					
31. DATE FILED (Month, Day, Year) APR 21 1995		32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13866

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) CHRISTOS DIMO SARBOV				2. DATE OF DEATH MONTH APRIL DAY 13 YEAR 95		3. TIME OF DEATH 0630 M	
4. SOCIAL SECURITY NUMBER 578-46-1801		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 87 YRS.		7. DATE OF BIRTH (Month, Day, Year) MAY 25, 1907	
8. BIRTHPLACE (State or Foreign Country) BULGARIA				9. COUNTY OF DEATH MONTGOMERY			
9a. FACILITY NAME (If not institution, give street and number) 6808 TULIP HILL TERRACE				9b. CITY, TOWN OR LOCATION OF DEATH BETHESDA		9c. COUNTY OF DEATH MONTGOMERY	
10a. STATE MARYLAND				10b. COUNTY MONTGOMERY		10c. CITY, TOWN OR LOCATION BETHESDA	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 6808 TULIP HILL TERRACE			
10f. ZIP CODE 20816				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) PRESIDENT		16b. KIND OF BUSINESS/INDUSTRY PARKING			
17. FATHER'S NAME (First, Middle, Last) DIMO SARBOV				18. MOTHER'S NAME (First, Middle, Maiden Surname) UNKNOWN			
19a. INFORMANT'S NAME (Type/Print) CHRISTINE S. SARBOV				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6808 TULIP HILL TER. BETHESDA, MD. 20816			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MT. COMFORT		DATE 4/18		20c. LOCATION — City or Town, State ALEXANDRIA, VA.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Heath M Peters				22. NAME AND ADDRESS OF FACILITY JOSEPH GAWLER'S SONS, INC 5130 WT. AVE. N.W. WASHINGTON, D.C. 20016			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. GUNSHOT WOUND HEAD DUE TO (OR AS A CONSEQUENCE OF): b. DEPRESSION DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death ACUTE 2 YRS
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) APRIL 12 95 0630A		28b. TIME OF INJURY 0630A		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED SHOT IN HEAD		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) HOME		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) #10			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Francis C. Mayle				29c. LICENSE NUMBER D07099		29d. DATE SIGNED (Month, Day, Year) APRIL 13 95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) FRANCIS C. MAYLE 10215 FERNWOOD RD BETHESDA MD 20814							
31. DATE FILED (Month, Day, Year) APR 18 1995		32. REGISTRAR'S SIGNATURE Julia Anderson-Randall					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.


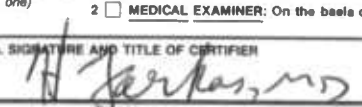
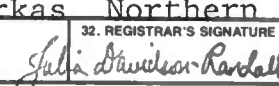
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13867

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Roger Boyd Speck				2. DATE OF DEATH MONTH DAY YEAR April 21 1995				3. TIME OF DEATH 12:25 P			
4. SOCIAL SECURITY NUMBER 213-44-8617		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 47 YRS.		7. DATE OF BIRTH (Month, Day, Year) February 19, 1948		8. BIRTHPLACE (State or Foreign Country) Maryland			
9a. FACILITY NAME (If not institution, give street and number) 1132 West Old Philadelphia Road				9b. CITY, TOWN OR LOCATION OF DEATH Charlestown				9c. COUNTY OF DEATH Cecil			
10a. STATE Maryland		10b. COUNTY Cecil		10c. CITY, TOWN OR LOCATION Charlestown				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 1132 West Old Philadelphia Road				10f. ZIP CODE 21914		10g. CITIZEN OF WHAT COUNTRY? United States					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES Vietnam		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) _____		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Operator Water Treatment Plant				16b. KIND OF BUSINESS/INDUSTRY US Government Veteran Facil.					
17. FATHER'S NAME (First, Middle, Last) Carl Lee Speck				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mildred Frances Wilson							
19a. INFORMANT'S NAME (Type/Print) Constance Diane Speck				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P. O. Box 256, Charlestown, MD 21914							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Charlestown Cemetery		DATE 4/24		20c. LOCATION — City or Town, State Charlestown, Maryland					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Crouch Funeral Home 127 South Main Street, North East, MD 21901							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Metastatic cancer of unknown primary site</u> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. _____ DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____								Approximate interval Between Onset and Death 7 months			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28t. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D15314		29d. DATE SIGNED (Month, Day, Year) April 21, 1995			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Henry Farkas Northern Chesapeake Hospice								239 S. Bridge Street Elkton, MD 21921			
31. DATE FILED (Month, Day, Year) APR 24 1995		32. REGISTRAR'S SIGNATURE 									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13868

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) DORIS MAY SPANGLER				2. DATE OF DEATH MONTH DAY YEAR April 18 1995		3. TIME OF DEATH 2105 M	
4. SOCIAL SECURITY NUMBER 214-28-0909		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 64 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Sept 9 1930	
8. BIRTHPLACE (State or Foreign Country) Maryland				9. FACILITY NAME (If not institution, give street and number) Washington County Hospital		10. CITY, TOWN OR LOCATION OF DEATH Hagerstown	
11. COUNTY OF DEATH Washington				12. RESIDENCE OF DECEDENT 10a. STATE Maryland		10b. COUNTY Washington	
10c. CITY, TOWN OR LOCATION Hagerstown				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 810 Medway Road	
10f. ZIP CODE 21740				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: White				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker				16b. KIND OF BUSINESS/INDUSTRY Her own home			
17. FATHER'S NAME (First, Middle, Last) William Fred Rickett				18. MOTHER'S NAME (First, Middle, Maiden Surname) Hazel Romaine Zeigler			
19a. INFORMANT'S NAME (Type/Print) Lawrence R. Spangler				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 810 Medway Road Hagerstown, Maryland 21740			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Hagerstown Crematory 4-19-95			
20c. LOCATION — City or Town, State Hagerstown, Maryland				21. SIGNATURE OF FUNERAL SERVICE LICENSEE Scott Minnich			
22. NAME AND ADDRESS OF FACILITY Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 21740				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Ischemic Heart Disease / Bleeding in brain			
IMMEDIATE CAUSE (Final disease or condition resulting in death) →				Approximate Interval Between Onset and Death 2 days			
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST				b. DUE TO (OR AS A CONSEQUENCE OF):			
c. DUE TO (OR AS A CONSEQUENCE OF):				d. DUE TO (OR AS A CONSEQUENCE OF):			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year) April 18 1995			
28b. TIME OF INJURY M				28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) Hagerstown, Maryland				28e. DESCRIBE HOW INJURY OCCURRED Ischemic Heart Disease			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) Hagerstown, Maryland				29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER John A. ... MD				29c. LICENSE NUMBER 20618			
29d. DATE SIGNED (Month, Day, Year) 4-19-95				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John A. ... Hagerstown, Maryland			
31. DATE FILED (Month, Day, Year) APR 20 1995				32. REGISTRAR'S SIGNATURE John A. ...			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13869

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Elsie Izora Shirley				2. DATE OF DEATH MONTH Apr DAY 14 YEAR 1995		3. TIME OF DEATH 0345 M	
4. SOCIAL SECURITY NUMBER 214-28-5519		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 92 YRS.		7. DATE OF BIRTH MONTH 3 DAY 25 YEAR 1903	
9a. FACILITY NAME (If not institution, give street and number) Washington County Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Hagerstown		9c. COUNTY OF DEATH Washington	
10a. STATE Maryland		10b. COUNTY Washington		10c. CITY, TOWN OR LOCATION Big Pool		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 11540 Ernstville Road				10f. ZIP CODE 21711		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR OATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Seamstress		16b. KIND OF BUSINESS/INDUSTRY Sewing Factory			
17. FATHER'S NAME (First, Middle, Last) Joseph Henry Pierce				18. MOTHER'S NAME (First, Middle, Maiden Surname) Eliza E. Hull			
19a. INFORMANT'S NAME (Type/Print) Anna M. Summers				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11540 Ernstville RD. Big Pool, MD 21711			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Parkhead Cemetery 4-17-95		20c. LOCATION — City or Town, State Big Pool, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Thompson Funeral Home, Inc. P.O. Box 310 Clear Spring, MD 21722			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. myocardial infarction DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { b. arteriosclerotic heart disease with c. arteriosclerosis DUE TO (OR AS A CONSEQUENCE OF): d. arteriosclerosis							Approximate Interval Between Onset and Death 24 hours many years many years
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. acute renal failure with uremia. dehydration. Post surgical state for resection of abdominal aorta							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER 007857		29d. DATE SIGNED (Month, Day, Year) 4/18/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. E.B. Moody 1190 Mt. Airy Road Hagerstown Md 21740							
31. DATE FILED (Month, Day, Year) APR 17 1995		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020



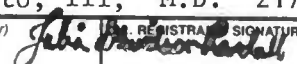
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13870

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Horace Francis SPALDING, Jr.				2. DATE OF DEATH MONTH DAY YEAR April 15, 1995				3. TIME OF DEATH 10:15 P M					
4. SOCIAL SECURITY NUMBER 219-20-0937		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		8. AGE (In yrs. last birthday) 66 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) Dec. 30, 1928		8. BIRTHPLACE (State or Foreign Country) Pennsylvania	
9a. FACILITY NAME (If not institution, give street and number) 11327 Manse Road						9b. CITY, TOWN OR LOCATION OF DEATH Hagerstown				9c. COUNTY OF DEATH Washington			
RESIDENCE OF DECEDENT													
10a. STATE Maryland		10b. COUNTY Washington		10c. CITY, TOWN OR LOCATION Hagerstown				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
10e. STREET AND NUMBER 11327 Manse Road						10f. ZIP CODE 21740				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES W.W.II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: white					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 0				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) brakeman				16b. KIND OF BUSINESS/INDUSTRY railroad					
17. FATHER'S NAME (First, Middle, Last) Horace Francis Spalding, Sr.						18. MOTHER'S NAME (First, Middle, Maiden Surname) Helen Fogle							
19a. INFORMANT'S NAME (Type/Print) Lucinda Grunberg						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18818 Rolling Road, Hagerstown, Maryland 21742							
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Hagerstown Crematory 4-17-95				20c. LOCATION — City or Town, State Hagerstown, Maryland					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Carcinoma of the Lung DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death 18 months Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER 						29c. LICENSE NUMBER D01062				29d. DATE SIGNED (Month, Day, Year) 4/17/95			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Edward W. Ditto, III, M.D. 217 W. Washington St. Hagerstown, Md 21740													
31. DATE FILED (Month, Day, Year) APR 19 1995				32. REGISTRAR'S SIGNATURE 									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2000 (10/1/00) 1000 * 11

95 13871

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) CARL DEWEY SOURS				2. DATE OF DEATH MONTH April DAY 11 YEAR 1995		3. TIME OF DEATH 0316 A M	
4. SOCIAL SECURITY NUMBER 217 30 5512		5. SEX 1 <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 59 YRS.		7. DATE OF BIRTH (Month, Day, Year) 5/6/35	
8. BIRTHPLACE (State or Foreign Country) Pennsylvania				9a. FACILITY NAME (If not institution, give street and number) Washington County Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Hagerstown	
9c. COUNTY OF DEATH Washington				10a. STATE MD		10b. COUNTY Washington	
10c. CITY, TOWN OR LOCATION Hagerstown				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 1041 Florida Avenue	
10f. ZIP CODE 21740				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 2 <input checked="" type="checkbox"/> Married 1957	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO Specify:		14. RACE — American Indian, Black (White), etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 0				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) self-employed truck driver		16b. KIND OF BUSINESS/INDUSTRY trucking	
17. FATHER'S NAME (First, Middle, Last) Commodore Dewey Sours				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mamie Susan Nicholson			
19a. INFORMANT'S NAME (Type/Print) Jeannie C. Sours				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1041 Florida Ave., Hagerstown, Maryland 21740			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Rest Haven Cemetery 4-14-95		20c. LOCATION — City or Town, State Hagerstown, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Scott M. Minnich				22. NAME AND ADDRESS OF FACILITY MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Massive Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF): Coronary Artery Disease DUE TO (OR AS A CONSEQUENCE OF): Arteriosclerotic Cardiovascular Disease DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death 8 hrs							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Left Heart Failure, Occlusion Left Femoral Artery							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide 3 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) N/A		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER MD				29c. LICENSE NUMBER D18127		29d. DATE SIGNED (Month, Day, Year) 4/11/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) C. Sours MD 370 Mill St. Hagerstown MD 21740							
31. DATE FILED (Month, Day, Year) APR 12 1995				32. REGISTRAR'S SIGNATURE John A. Parker			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13872

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last) MARY MAE SHANK				2. DATE OF DEATH MONTH APRIL DAY 20 YEAR 1995		3. TIME OF DEATH 2:33 A. M.	
4. SOCIAL SECURITY NUMBER 220-28-3767		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (in yrs. last birthday) 60 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 11, 1934	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) University of Maryland Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City	
9c. COUNTY OF DEATH							
10a. STATE Maryland		10b. COUNTY Washington		10c. CITY, TOWN OR LOCATION Hagerstown		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 13910 North Meadow Road				10f. ZIP CODE 21742		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home	
17. FATHER'S NAME (First, Middle, Last) Charles Alton Gabe				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Catherine Mauk			
19a. INFORMANT'S NAME (Type/Print) William G. Shank				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13910 North Meadow Road, Hagerstown, Md. 21740			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Rest Haven Cemetery 04-24-95		20c. LOCATION — City or Town, State Hagerstown, Maryland		20d. DATE 04-24-95	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE R. Noel Brady				22. NAME AND ADDRESS OF FACILITY Andrew K. Coffman Funeral Home, Inc. 40 East Antietam St., Hagerstown, Md. 21740			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → CAECAL CANCER & CLOSTRIDIAL GAS GANGRENE Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. SEPTICEMIA c. MULTIPLE ORGAN FAILURE d. MORBID OBESITY & DIABETES							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MORBID OBESITY & DIABETES							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER R. Noel Brady TRAUMA SURGEON				29c. LICENSE NUMBER D23286		29d. DATE SIGNED (Month, Day, Year) APRIL 20/1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) R.A.M. MIERS STROKE TRAUMA CENTER, UNIV OF MARYLAND, 22 S. GREENE STREET BALTIMORE							
31. DATE FILED (Month, Day, Year) APR. 24 1995				32. REGISTRAR'S SIGNATURE Johi [Signature]			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13873

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ORPHA LOUISE SHILLING				2. DATE OF DEATH MONTH APRIL DAY 10 YEAR 1995		3. TIME OF DEATH 1608 PM	
4. SOCIAL SECURITY NUMBER 217-18-8812		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 88 YRS.	7. DATE OF BIRTH MONTH FEB. DAY 10 YEAR 1907		8. BIRTHPLACE (State or Foreign Country) MARYLAND	
9a. FACILITY NAME (If not institution, give street and number) WASHINGTON COUNTY HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH HAGERSTOWN		9c. COUNTY OF DEATH WASHINGTON	
10a. STATE MARYLAND		10b. COUNTY WASHINGTON		10c. CITY, TOWN OR LOCATION HAGERSTOWN		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 19727 SHILOH CHURCH ROAD				10f. ZIP CODE 21740		10g. CITIZEN OF WHAT COUNTRY? U.S.A	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 5 College (1-4 or 5+) 		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) COOK		16b. KIND OF BUSINESS/INDUSTRY RESTAURANT			
17. FATHER'S NAME (First, Middle, Last) JOHN BOWMAN				18. MOTHER'S NAME (First, Middle, Maiden Surname) LILY BROWN			
19a. INFORMANT'S NAME (Type/Print) EMMA V. SPRANKLE				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16549 NATIONAL PIKE, HAGERSTOWN, MARYLAND 21740			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) ROSE HILL CEMETERY 04-13-95		20c. LOCATION — City or Town, State HAGERSTOWN, MARYLAND		20d. DATE 04-13-95	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE R. Noel Brady				22. NAME AND ADDRESS OF FACILITY ANDREW K. COFFMAN FUNERAL HOME, INC. 40 E. ANTIETAM ST., HAGERSTOWN, MD. 21740			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Ruptured abdominal aortic aneurysm DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate interval Between Onset and Death 1 Day
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined			
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> 1. CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> 2. MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Q. Healey				29c. LICENSE NUMBER D21457		29d. DATE SIGNED (Month, Day, Year) 4/11/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ABOUL WATHEED MD - 12821 OAKHILL AVE HAGERSTOWN MD 21742							
31. DATE FILED (Month, Day, Year) APR 13 1995				32. REGISTRAR'S SIGNATURE John B. ...			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Amended, item #6, 2/24/95; Harford County, S.B. 5 13874

FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) CLEVELAND TANNER STOREY				2. DATE OF DEATH MONTH DAY YEAR APRIL 20, 1995		3. TIME OF DEATH 8:40 AM					
4. SOCIAL SECURITY NUMBER 255-16-7318		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 73 72 YRS.		7. DATE OF BIRTH (Month, Day, Year) March 12, 1923		8. BIRTHPLACE (State or Foreign Country) Georgia			
9a. FACILITY NAME (If not institution, give street and number) 926 Hamburg Dr.				9b. CITY, TOWN OR LOCATION OF DEATH Abingdon			9c. COUNTY OF DEATH Harford				
10a. STATE Maryland				10b. COUNTY Harford		10c. CITY, TOWN OR LOCATION Abingdon		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 926 Hamburg Dr.				10f. ZIP CODE 21009		10g. CITIZEN OF WHAT COUNTRY? USA					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) 6				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Painter		16b. KIND OF BUSINESS/INDUSTRY Construction					
17. FATHER'S NAME (First, Middle, Last) Dock Cleveland Storey				18. MOTHER'S NAME (First, Middle, Maiden Surname) Harold Lena Gibson							
19a. INFORMANT'S NAME (Type/Print) Audrey C. Dorohovich				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 926 Hamburg Dr., Abingdon, Md. 21009							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gardens of Faith Cemetery 4-24-95		20c. LOCATION — City or Town, State Baltimore, Md.		22. NAME AND ADDRESS OF FACILITY Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, Md. 21009					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, Md. 21009							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. EMPHYSEMA								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		26. PLACE OF DEATH (Check only one) OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28i. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER Richard J. [Signature] DEPUTY MEDICAL EXAMINER				29c. LICENSE NUMBER OCME		29d. DATE SIGNED (Month, Day, Year) APRIL 20, 1995					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)											
31. DATE FILED (Month, Day, Year) APR 21 1995				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Revised 10/10/80

95 13875

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Harry Sugimoto				2. DATE OF DEATH MONTH DAY YEAR 4-18-95		3. TIME OF DEATH 9:16 p m	
4. SOCIAL SECURITY NUMBER 568-20-7020		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 92 YRS.		7. DATE OF BIRTH (Month, Day, Year) 12-3-02	
8. BIRTHPLACE (State or Foreign Country) Japan				9a. FACILITY NAME (If not institution, give street and number) Anne Arundel Medical Center		9b. CITY, TOWN OR LOCATION OF DEATH Annapolis	
9c. COUNTY OF DEATH Anne Arundel				10a. STATE Maryland		10b. COUNTY Anne Arundel	
10c. CITY, TOWN OR LOCATION Severna Park				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 202 Sycamore Road	
10f. ZIP CODE 21146				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: Asian				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 8			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Gardener				16b. KIND OF BUSINESS/INDUSTRY Gardening			
17. FATHER'S NAME (First, Middle, Last) Yuitsu Sugimoto				18. MOTHER'S NAME (First, Middle, Maiden Surname) Toshie Yoshida			
19a. INFORMANT'S NAME (Type/Print) Marlene Sugimoto				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as # 10			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory 4-21-95			
20c. LOCATION — City or Town, State Catonsville, MD				21. SIGNATURE OF FUNERAL SERVICE LICENSEE 			
22. NAME AND ADDRESS OF FACILITY Barranco and Sons Funeral Home 495 Ritchie Hwy Severna Park MD 21146				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. HEART FAILURE / PNEUMONIA b. DUE TO (OR AS A CONSEQUENCE OF): c. PROSTATE CARCINOMA d. COPD BY HISTORY Approximate Interval Between Onset and Death 72 HRS NA			
24. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HAD RECENT PROSTATE SURGERY AT AMMC IN PNEUMATIC HEART DISEASE DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined			
28a. DATE OF INJURY (Month, Day, Year) NA				28b. TIME OF INJURY NA			
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED NA			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) NA				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) NA			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER 			
29c. LICENSE NUMBER D32088				29d. DATE SIGNED (Month, Day, Year) 4/15/95			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) EDWARD M. ZAGULA, M.D. 600 RIDGELY AVE, STE 130, ANNAPOLIS, MD 21401							
31. DATE FILED (Month, Day, Year) APR 21 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13876

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) VINCENT F. SIMMS				2. DATE OF DEATH MONTH APRIL DAY 12 YEAR 1995		3. TIME OF DEATH 12:30pm M	
4. SOCIAL SECURITY NUMBER 212-60-0620		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 42 YRS.		7. DATE OF BIRTH (Month, Day, Year) NOV. 20 1952	
8. BIRTHPLACE (State or Foreign Country) MARYLAND				9a. FACILITY NAME (If not Institution, give street and number) MERIDIAN SPAA CREEK		9b. CITY, TOWN OR LOCATION OF DEATH ANNAPOLIS	
9c. COUNTY OF DEATH ANNE ARUNDEL				10a. STATE MARYLAND		10b. COUNTY ANNE ARUNDEL	
10c. CITY, TOWN OR LOCATION EDGEWATER				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 139 DORSEY DRIVE	
10f. ZIP CODE 21037				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1979 - 1984				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) MUSICIAN		16b. KIND OF BUSINESS/INDUSTRY SELF EMPLOYED	
17. FATHER'S NAME (First, Middle, Last) DAVID SIMMS				18. MOTHER'S NAME (First, Middle, Maiden Surname) MARY SIMMS			
19a. INFORMANT'S NAME (Type/Print) MARY SIMMS				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 139 DORSEY DR. EDGEWATER, MD. 21037			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MARYLAND VETERAN CEME. 4/17/95		20c. LOCATION — City or Town, State CROWNSVILLE, MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Larry H. Reese</i>				22. NAME AND ADDRESS OF FACILITY REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
a. <i>Acquired Immunodeficiency Syndrome</i>							
DUE TO (OR AS A CONSEQUENCE OF):							
b. <i>Cryptococcal meningitis</i>							
DUE TO (OR AS A CONSEQUENCE OF):							
c. <i>Brain mass</i>							
DUE TO (OR AS A CONSEQUENCE OF):							
d. _____							
Approximate interval Between Onset and Death a. <i>dx'd 1990</i> b. <i>2 1/2 yrs</i> c. <i>1 month</i>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>J. Serlemitsos M.D.</i>				29c. LICENSE NUMBER D32654		29d. DATE SIGNED (Month, Day, Year) 4/14/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 180 Admiral Cochrane Dr. Annapolis, MD 21401							
31. DATE FILED (Month, Day, Year) APR 18 1995				32. REGISTRAR'S SIGNATURE <i>John Davidson Rostell</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13877

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) George Ignatius Seybold				2. DATE OF DEATH MONTH DAY YEAR Apr 17 1995		3. TIME OF DEATH 5:45am M	
4. SOCIAL SECURITY NUMBER 164-14-0683		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 89 YRS.		7. DATE OF BIRTH (Month, Day, Year) Feb 23 1906	
9a. FACILITY NAME (If not institution, give street and number) Calvert Manor Nursing Home				9b. CITY, TOWN OR LOCATION OF DEATH Rising Sun		9c. COUNTY OF DEATH Cecil	
RESIDENCE OF DECEDENT							
10a. STATE MD		10b. COUNTY Harford		10c. CITY, TOWN OR LOCATION Churchville		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 3350 Level Rd				10f. ZIP CODE 21028		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) unknown		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Engineering Firm		16b. KIND OF BUSINESS/INDUSTRY Engineer			
17. FATHER'S NAME (First, Middle, Last) James Seybold				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mimmi Zell			
19a. INFORMANT'S NAME (Type/Print) George I. Seybold				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3362 Level Rd Churchville MD 21028			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) R A Ferris April 17 1995		20c. LOCATION — City or Town, State West Chester, PA			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY R T Foard Funeral Home 111 S Queen St Rising Sun MD 21911			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <u>Cancer of lung</u> DUE TO (OR AS A CONSEQUENCE OF):				Approximate Interval Between Onset and Death 2 YRS	
Sequently ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. <u>Metastatic Cancer to Rebs</u> DUE TO (OR AS A CONSEQUENCE OF):				1 YR	
		c. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D09482		29d. DATE SIGNED (Month, Day, Year) 4/17/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type, Print) 2017 Troop Church Rd Darkington Ind 21034-Bx 300							
31. DATE FILED (Month, Day, Year) APR 18 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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95 13878

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) <i>Wells Stidoms SR.</i>				2. DATE OF DEATH MONTH <i>April</i> DAY <i>14</i> YEAR <i>95</i>		3. TIME OF DEATH <i>4 10 A.M.</i>	
4. SOCIAL SECURITY NUMBER <i>214-20-2428</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>73</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>1-24-1922</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Union Hospital</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Elkton</i>		9c. COUNTY OF DEATH <i>Cecil</i>	
RESIDENCE OF DECEASED							
10a. STATE <i>MD</i>		10b. COUNTY <i>Cecil</i>		10c. CITY, TOWN OR LOCATION <i>Elkton</i>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <i>691 Augustine Herman Highway</i>				10f. ZIP CODE <i>21921</i>		10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify <i>White</i>	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i></i>				16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>MAINTENANCE</i>		16b. KIND OF BUSINESS/INDUSTRY <i>TRUCK STOP</i>	
17. FATHER'S NAME (First, Middle, Last) <i>Jesse Stidoms</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Rosa Richardson</i>			
19a. INFORMANT'S NAME (Type/Print) <i>NORMA Stidoms</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>691 Augustine Herman Highway Elkton, MD 21921</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium, etc. (Specify)) <i>Opoka Cem 4/19</i>		20c. LOCATION — City or Town, State <i>Opoka 19363</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Edward Holm</i>				22. NAME AND ADDRESS OF FACILITY <i>Collins Funeral Home Opoka 19363</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>acute myocardial infarction</i>							
a. DUE TO (OR AS A CONSEQUENCE OF):							
b. <i>ASCVD</i>							
c. <i>Diabetic Mellitus</i>							
d.							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> A <input type="checkbox"/> P <input type="checkbox"/> NO	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE NOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Jui-chih Hsu MD</i>				29c. LICENSE NUMBER <i>D04823</i>		29d. DATE SIGNED (Month, Day, Year) <i>4/14/95</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Jui-chih Hsu, MD 223 West main st. Elkton Md 21921</i>							
31. DATE FILED (Month, Day, Year) <i>APR 17 1995</i>				32. REGISTRAR'S SIGNATURE <i>Johi Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13879

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) VIRGINIA SLICER SCHENCK				2. DATE OF DEATH MONTH April DAY 12 YEAR 1995		3. TIME OF DEATH 6:25 P. M.	
4. SOCIAL SECURITY NUMBER 265-38-8632		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 88 YRS.		7. DATE OF BIRTH (Month, Day, Year) March 5, 1907	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) Dulaney Towson Nursing Home		9b. CITY, TOWN OR LOCATION OF DEATH Towson	
9c. COUNTY OF DEATH Baltimore				10a. STATE Maryland		10b. COUNTY Baltimore	
10c. CITY, TOWN OR LOCATION Towson				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 6 Midcrest Court	
10f. ZIP CODE 21286				10g. CITIZEN OF WHAT COUNTRY? United States		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: White				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 years			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Elementary School Teacher				16b. KIND OF BUSINESS/INDUSTRY Education			
17. FATHER'S NAME (First, Middle, Last) John Benjamin Slicer				18. MOTHER'S NAME (First, Middle, Maiden Surname) Eva England			
19a. INFORMANT'S NAME (Type/Print) John E. Schenck				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6 Midcrest Court, Towson, Maryland 21286			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) R. A. Ferris & Company 4/13/95 West Chester, PA			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY R. T. Foard Funeral Home 111 S. Queen St., Rising Sun, MD 21911			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cerebrovascular Insufficiency DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER 013272		29d. DATE SIGNED (Month, Day, Year) 4-13-95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Robert E. Stoner, M.D. 120 Sr. Pierre Dr., Towson, Md. 21204							
31. DATE FILED (Month, Day, Year) APR 13 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95-2126-031

DWG

UNK 95-104

95 13880

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) BRIAN KEITH TONEY				2. DATE OF DEATH MONTH APRIL DAY 12 YEAR 95		3. TIME OF DEATH 1210P M	
4. SOCIAL SECURITY NUMBER 218-02-9115		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 28 YRS.		7. DATE OF BIRTH (Month, Day, Year) Oct. 10, 1966	
8. BIRTHPLACE (State or Foreign Country) Washington, D.C.				9a. FACILITY NAME (If not institution, give street and number) SHADY GROVE HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH OLNEY	
9c. COUNTY OF DEATH MONTGOMERY				10. RESIDENCE OF DECEDENT			
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Silver Spring		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 11516 Joseph Mill Road				10f. ZIP CODE 20906		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Laborer		16b. KIND OF BUSINESS/INDUSTRY Construction			
17. FATHER'S NAME (First, Middle, Last) Arthur Lee Toney				18. MOTHER'S NAME (First, Middle, Maiden Surname) Bonnie Lee Kerwood			
19a. INFORMANT'S NAME (Type/Print) Arthur Lee Toney				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11516 Joseph Mill Road Silver Spring, Maryland 20906			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Cemetery Greenshools Toney Family 4/19/95		20c. LOCATION — City or Town, State Leet, West Virginia		20d. DATE 4/19/95	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Christopher Marshall</i>				22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Sil. Spr., MD 20901			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Multiple Injuries DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 4-12-95		28b. TIME OF INJURY 1152 AM		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED Passenger - auto - collision		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) Roadway		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) ML Nebo Rd / River Rd			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) APRIL 13/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) David R Fowler PENN STREET, BALTIMORE, MARYLAND 21201							
31. DATE FILED (Month, Day, Year) APR 17 1995		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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95 13881

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Evelyn Fritts Thrift				2. DATE OF DEATH MONTH April 17, DAY 1995 YEAR		3. TIME OF DEATH 3:36 A M	
4. SOCIAL SECURITY NUMBER 577-09-7559		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 90 YRS.		7. DATE OF BIRTH (Month, Day, Year) Dec. 21, 1904	
8a. FACILITY NAME (If not institution, give street and number) 303 Hillmoor Drive				8b. CITY, TOWN OR LOCATION OF DEATH Silver Spring		8c. BIRTHPLACE (State or Foreign Country) Iowa	
9a. RESIDENCE OF DECEDENT 10a. STATE Maryland				10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Silver Spring	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 303 Hillmoor Drive			
10f. ZIP CODE 20901				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Dental Assistant		16b. KIND OF BUSINESS/INDUSTRY Dental			
17. FATHER'S NAME (First, Middle, Last) William T. Fritts				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Katherine Printz			
19a. INFORMANT'S NAME (Type/Print) Ann T. Malpass				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10214 Big Rock Road Silver Spring, Maryland 20901			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gibson Baptist Church Cem. 4/19/95		20c. LOCATION — City or Town, State Village, Virginia		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>March L. Willett</i>				22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd. W. Sil. Spr. MD 20901			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Pancreatic carcinoma.</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>not contributed to by tobacco - Heckman, M.D.</i> DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Bernard A. Heckman, M.D.</i>				29c. LICENSE NUMBER D0 5373		29d. DATE SIGNED (Month, Day, Year) 4/18/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Bernard A. Heckman, M.D. 8830 Cameron Street #405 Silver Spring, MD. 20910-4114							
31. DATE FILED (Month, Day, Year) APR 19 1995				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

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95 13882

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Mildred Dennis Taylor				2. DATE OF DEATH MONTH April 17, DAY 1995 YEAR				3. TIME OF DEATH 5:05 P M			
4. SOCIAL SECURITY NUMBER 462-10-7922		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 82 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) March 6, 1913		8. BIRTHPLACE (State or Foreign Country) Texas	
9a. FACILITY NAME (If not institution, give street and number) Manor Care Bethesda				9b. CITY, TOWN OR LOCATION OF DEATH Chevy Chase				9c. COUNTY OF DEATH Montgomery			
RESIDENCE OF DECEDENT											
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Silver Spring				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 8214 Cedar Street				10f. ZIP CODE 20910				10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Librarian				16b. KIND OF BUSINESS/INDUSTRY Dept. of the Army			
17. FATHER'S NAME (First, Middle, Last) Reuben Albion Taylor						18. MOTHER'S NAME (First, Middle, Maiden Surname) Mabel Annie Dennis					
19a. INFORMANT'S NAME (Type/Print) Albion D. Taylor				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as 10							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Nevada Cemetery				DATE 4-22		20c. LOCATION — City or Town, State Nevada, Texas	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Eileen W. Rapp				22. NAME AND ADDRESS OF FACILITY Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Alzheimer's Disease DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.										Approximate Interval Between Onset and Death 8 Yrs	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Multiple infarct disease, Hypertension											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28i. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER Jila I. McConnell						29c. LICENSE NUMBER D39456		29d. DATE SIGNED (Month, Day, Year) April 17, 1995			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Jila I. McConnell, M.D. 5530 Wisconsin Ave, Chevy Chase, MD 20815											
31. DATE FILED (Month, Day, Year) APR 19 1995				32. REGISTRAR'S SIGNATURE Julia Davidson Randall							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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95 13883

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Gordon Torrey				2. DATE OF DEATH MONTH DAY YEAR March 28, 1995		3. TIME OF DEATH 0710 A	
4. SOCIAL SECURITY NUMBER 541-22-4375		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (in yrs. last birthday) 75 YRS.		7. DATE OF BIRTH (Month, Day, Year) 12/4/1919	
8. BIRTHPLACE (State or Foreign Country) Eugene Oregon				9a. FACILITY NAME (If not institution, give street and number) Shady Grove Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Rockville	
9c. COUNTY OF DEATH Montgomery				10a. STATE Maryland		10b. COUNTY Montgomery	
10c. CITY, TOWN OR LOCATION Gaithersburg				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 392 Russell Avenue	
10f. ZIP CODE 20877				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: WHITE				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (8-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> 5+			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Analylsis				16b. KIND OF BUSINESS/INDUSTRY CIA			
17. FATHER'S NAME (First, Middle, Last) Raymond Torrey				18. MOTHER'S NAME (First, Middle, Maiden Surname) Minnie Marsh			
19a. INFORMANT'S NAME (Type/Print) Ann Inbseth Torrey				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 392 Russell Avenue, Gaithersburg, MD. 20877			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Georgetown Med. School 3/28/95 Washington, D.C.			
20c. LOCATION — City or Town, State				21. SIGNATURE OF FUNERAL SERVICE LICENSEE 			
22. NAME AND ADDRESS OF FACILITY Austin Royster Funeral Home 3605 14th Street N.W. Wash, DC 20010				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Adverse reaction to medication Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. Chronic Depression b. c. d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dehydration and malnutrition associated with ileostomy for inflammatory bowel disease. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>			
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year) March 28, 1995			
28b. TIME OF INJURY M				28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER Byrl D. Johnson M.D.				29c. LICENSE NUMBER D-19042			
29d. DATE SIGNED (Month, Day, Year) March 28, 1995				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Byrl D. Johnson M.D., 911 Russell Avenue, Gaithersburg, MD. 20879			
31. DATE FILED (Month, Day, Year) APR 14 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

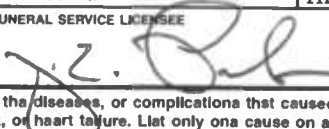
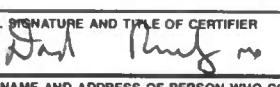
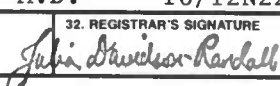
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13884

1 FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Marie TRANTOW				2. DATE OF DEATH MONTH DAY YEAR April 13, 1995		3. TIME OF DEATH 6:45 P. M	
4. SOCIAL SECURITY NUMBER 326-26-3865		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) 60 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 15, 1934	
9a. FACILITY NAME (If not institution, give street and number) 8111 Needwood Road Apt. # T 102		9b. CITY, TOWN OR LOCATION OF DEATH Derwood		9c. COUNTY OF DEATH Montgomery			
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Derwood		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 8111 Needwood Road Apt. # T 102				10f. ZIP CODE 20855		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) 4		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Home Maker		16b. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) Salvatore Blando				18. MOTHER'S NAME (First, Middle, Maiden Surname) Josephine Restivo			
19a. INFORMANT'S NAME (Type/Print) Donald J. Trantow				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8111 Needwood Rd. Apt. # T 102, Derwood, MD 20855			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Andersonville Nat. Cem. 4/17		20c. LOCATION — City or Town, State Andersonville, Georgia			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY DeVol Funeral Home 10 E. Deer Park Dr., Gaithersburg, MD 20877			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastatic Breast Cancer DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death 6 years
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D40854		29d. DATE SIGNED (Month, Day, Year) April 14, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) David Riseberg, M.D. 10/12N226 NCI, 9000 Rockville Pike, Bethesda, MD 20892							
31. DATE FILED (Month, Day, Year) APR 18 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13885

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Anna Anastasia Taylor				2. DATE OF DEATH MONTH DAY YEAR April 16, 1995		3. TIME OF DEATH 9:20 p.m.	
4. SOCIAL SECURITY NUMBER 345-01-3392		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 87 YRS.	7. DATE OF BIRTH (Month, Day, Year) Sept. 4, 1907		8. BIRTHPLACE (State or Foreign Country) Russia	
9a. FACILITY NAME (If not institution, give street and number) 310 Summit Hall Road				9b. CITY, TOWN OR LOCATION OF DEATH Gaithersburg		9c. COUNTY OF DEATH Montgomery	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Gaithersburg		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 310 Summit Hall Road				10f. ZIP CODE 20877		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife		16b. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) William Janakauskas				18. MOTHER'S NAME (First, Middle, Maiden Surname) Sally Vaitkus			
19a. INFORMANT'S NAME (Type/Print) Lana Cerny				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 310 Summit Hall Road, Gaithersburg, MD 20877			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Memorial Park 4/19/95		20c. LOCATION — City or Town, State St. Petersburg, Florida			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Michael D. Gibbons				22. NAME AND ADDRESS OF FACILITY DeVol Funeral Home 10 East Deer Park Drive Gaithersburg, MD 20877			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. squamous cell carcinoma - mandible DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. DESCRIBE HOW INJURY OCCURRED			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Pasqual Perrino MD				29c. LICENSE NUMBER D12438		29d. DATE SIGNED (Month, Day, Year) 4/17/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Pasqual Perrino 15225 Shady Grove Road #105, Rockville, MD 20850-3283							
31. DATE FILED (Month, Day, Year) APR 18 1995				32. REGISTRAR'S SIGNATURE John Davidson Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13886

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARY LOUISE TENLEY				2. DATE OF DEATH MONTH DAY YEAR APR 12 1995		3. TIME OF DEATH A M 4:05	
4. SOCIAL SECURITY NUMBER 579-26-0141		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 68 YRS.		7. DATE OF BIRTH (Month, Day, Year) Jan. 31, 1927	
8. BIRTHPLACE (State or Foreign Country) Ohio				9a. FACILITY NAME (If not institution, give street and number) NATIONAL NAVAL MEDICAL CENTER		9b. CITY, TOWN OR LOCATION OF DEATH BETHESDA	
9c. COUNTY OF DEATH MONTGOMERY				10a. STATE Maryland		10b. COUNTY Montgomery	
10c. CITY, TOWN OR LOCATION Wheaton				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 11802 Huggins Drive	
10f. ZIP CODE 20902				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Secretary		16b. KIND OF BUSINESS/INDUSTRY Walter Reed			
17. FATHER'S NAME (First, Middle, Last) Harry Alan McMasters				18. MOTHER'S NAME (First, Middle, Maiden Surname) Henrietta White			
19a. INFORMANT'S NAME (Type/Print) Brenda Tenley				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11802 Huggins Drive, Wheaton, Maryland 20902			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Arlington National Cemetery 4/18		20c. LOCATION — City or Town, State Arlington, Virginia		21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Louis Trent Holland</i>	
22. NAME AND ADDRESS OF FACILITY Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland 20904		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or renal failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. END STAGE CHRONIC OBSTRUCTIVE LUNG DISEASE DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate interval between Onset and Death 15 years					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO						25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>N Lee MD.</i>				29c. LICENSE NUMBER 0101-050077 (VA)		29d. DATE SIGNED (Month, Day, Year) 4-12-95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) NORMAN LEE, LT, MC, USNR BETHESDA MD 20889-5600							
31. DATE FILED (Month, Day, Year) APR 17 1995				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13887

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) RALPH VERNON TONEY				2. DATE OF DEATH MONTH APRIL DAY 14 YEAR 95		3. TIME OF DEATH 1029A M	
4. SOCIAL SECURITY NUMBER 714-18-1267		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 70 YRS.		7. DATE OF BIRTH (Month, Day, Year) May 29, 1924	
9a. FACILITY NAME (If not institution, give street and number) Suburban Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Bethesda		9c. COUNTY OF DEATH Montgomery	
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Potomac		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 11615 Greenlane Drive				10f. ZIP CODE 20854		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES World War II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Comptroller		16b. KIND OF BUSINESS/INDUSTRY Insurance			
17. FATHER'S NAME (First, Middle, Last) Elmer Toney				18. MOTHER'S NAME (First, Middle, Maiden Surname) Vera Conn			
19a. INFORMANT'S NAME (Type/Print) Margaret Garner Toney				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11615 Greenlane Drive, Potomac, Maryland 20854			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gate of Heaven Cemetery April 18, 1995		20c. LOCATION — City or Town, State Silver Spring, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Barbara J. McMullen Lawrence</i>		M00831		22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. arteriosclerotic heart disease DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate interval Between Onset and Death years
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John Tamber</i>				29c. LICENSE NUMBER D08546		29d. DATE SIGNED (Month, Day, Year) April 14 95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John Tamber 8218 Wisconsin Ave Bethesda MD							
31. DATE FILED (Month, Day, Year) APR 17 1995				32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

ITEMS: 23 PART I, 27, PER MEO FILM G-724 6/5/95 t.t

95 13888

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) GENEVA MARY TIPPETT		2. DATE OF DEATH MONTH DAY YEAR APRIL 24 95		3. TIME OF DEATH 10:01 P.M.	
4. SOCIAL SECURITY NUMBER 217-28-7998		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) YRS.	
7. DATE OF BIRTH (Month, Day, Year) Nov. 3, 1930		8. BIRTHPLACE (State or Foreign Country) Maryland			
9a. FACILITY NAME (If not institution, give street and number) ST. MARYS HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH LEONARDTOWN		9c. COUNTY OF DEATH ST. MARYS	
10a. STATE Maryland		10b. COUNTY St. Mary's		10c. CITY, TOWN OR LOCATION Charlotte Hall	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER Rt. 1 Box 195		10f. ZIP CODE 20622	
10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 8		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife		16b. KIND OF BUSINESS/INDUSTRY Home	
17. FATHER'S NAME (First, Middle, Last) William Henry Kidwell		18. MOTHER'S NAME (First, Middle, Maiden Surname) Janie M. Boswell			
19a. INFORMANT'S NAME (Type/Print) Jane A. Raffo		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1609-A Airy Hill Court, Crofton, MD 21114			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Trinity Memorial Gardens 4-29		20c. LOCATION — City or Town, State Waldorf, MD 20601	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Benjamin M. Matthews M00658		22. NAME AND ADDRESS OF FACILITY Huntt Funeral Home P. O. box 156, Waldorf, MD 20604-0156			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → CHRONIC OBSTRUCTIVE PULMONARY DISEASE DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.					Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>					24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER J. A. Raffo, MD		29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) APRIL 27, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Tracy Locke, MD 111 Penn Street, Baltimore, Maryland 21201					
31. DATE FILED (Month, Day, Year) MAY 03 1995		32. REGISTRAR'S SIGNATURE John A. Randall			

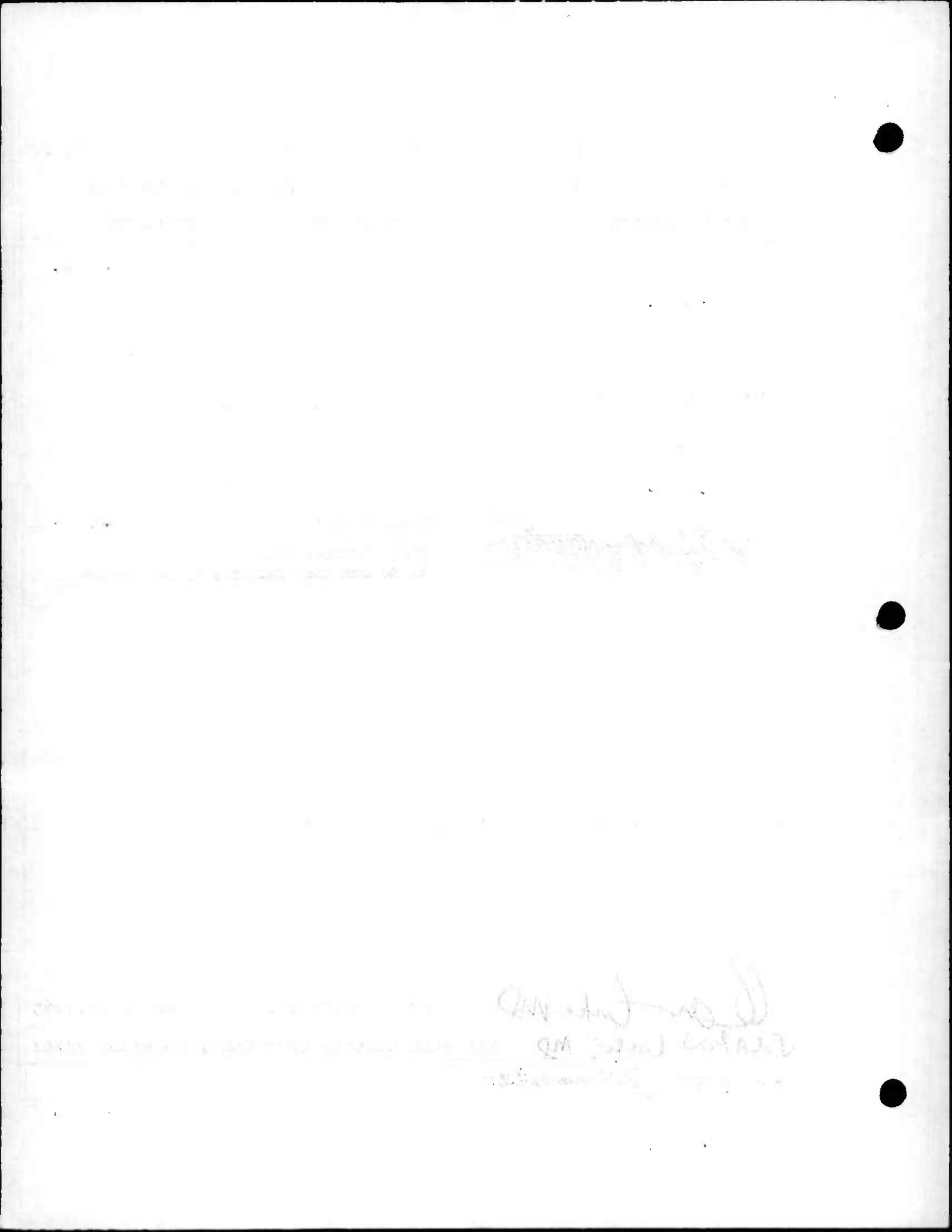
TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 13889

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Barbara Ellen TAYLOR				2. DATE OF DEATH MONTH DAY YEAR April 24, 1995		3. TIME OF DEATH 10:00 a. m.		
4. SOCIAL SECURITY NUMBER 168-36-9022		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 45 YRS.	7. DATE OF BIRTH (Month, Day, Year) April 24, 1950	8. BIRTHPLACE (State or Foreign Country) Pennsylvania			
9a. FACILITY NAME (If not institution, give street and number) 201 East Avenue				9b. CITY, TOWN OR LOCATION OF DEATH Hagerstown		9c. COUNTY OF DEATH Washington		
RESIDENCE OF DECEDENT								
10a. STATE Maryland		10b. COUNTY Washington		10c. CITY, TOWN OR LOCATION Hagerstown		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		
10e. STREET AND NUMBER 201 East Avenue				10f. ZIP CODE 21740		10g. CITIZEN OF WHAT COUNTRY? USA		
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) housewife		16b. KIND OF BUSINESS/INDUSTRY her own home				
17. FATHER'S NAME (First, Middle, Last) Owen Clarence Meyers				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ella Ruth Reeder				
19a. INFORMANT'S NAME (Type/Print) Jesse Taylor				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 213 West Side Avenue, Hagerstown, Md. 21740				
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Leitersburg Cemetery 4-27-95		20c. LOCATION — City or Town, State Leitersburg, Maryland		20d. DATE 4-27-95		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Scott Minnick</i>				22. NAME AND ADDRESS OF FACILITY MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740				
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>CORONARY OCCLUSION</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. <i>atherosclerotic disease</i> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death <i>sudden</i>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>								
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. SIGNATURE AND TITLE OF CERTIFIER <i>R. N. Weeks</i>				29c. LICENSE NUMBER D11266		29d. DATE SIGNED (Month, Day, Year) 4/25/95		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) R. N. Weeks 580 Northern Ave Hagerstown Md								
31. DATE FILED (Month, Day, Year) APR 25 1995				32. REGISTRAR'S SIGNATURE <i>John D. ...</i>				

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1958-1959

95-1993-025

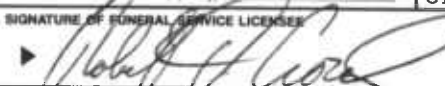

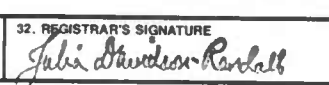
DWG

AMENDED # 1, 4-12-95, E.J.A., Cecil

95 13890

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARGERITA MARGARITA				2. DATE OF DEATH MONTH APRIL DAY 08 YEAR 95				3. TIME OF DEATH 7:55A M		
4. SOCIAL SECURITY NUMBER 218-18-9992		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 79 YRS.	IF UNDER 1 YEAR MONTHS 7 DAYS 1926		IF UNDER 24 HRS. HOURS 7 MIN. 1926		7. DATE OF BIRTH (Month, Day, Year) February 7 1926		8. BIRTHPLACE (State or Foreign Country) Maine
9a. FACILITY NAME (If not institution, give street and number) HARFORD MEMORIAL HOSP.				9b. CITY, TOWN OR LOCATION OF DEATH HAVRE DE GRACE				9c. COUNTY OF DEATH HARFORD		
RESIDENCE OF DECEDENT										
10a. STATE Maryland		10b. COUNTY Harford		10c. CITY, TOWN OR LOCATION Havre de Grace				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
10e. STREET AND NUMBER 4145 Webster Lapidum Road				10f. ZIP CODE 21078		10g. CITIZEN OF WHAT COUNTRY? United States				
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker				16b. KIND OF BUSINESS/INDUSTRY Her Own Home				
17. FATHER'S NAME (First, Middle, Last) Lloyd Ralph Kelly				18. MOTHER'S NAME (First, Middle, Maiden Surname) Victoria Mathias						
19a. INFORMANT'S NAME (Type/Print) Mike Tarbert				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 608 South Washington Street, Havre de Grace MD 21078						
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Cremation Specialists		DATE 4/10		20c. LOCATION — City or Town, State Media, Pennsylvania				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Crouch Funeral Home, 127 South Main Street North East, MD 21901						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Perforation of esophagus with complications DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.										
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes mellitus, Hypertensive Atherosclerotic Cardiovascular Disease History of Pulmonary Embolism DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>										
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> XER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> 4 Nursing Home <input type="checkbox"/> 5 Residence <input type="checkbox"/> 6 Other (Specify)								
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) 3-21-95		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED therapeutic procedure		
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) Hospital		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) Harford Memorial Hosp. Inc. Harford Co., MD								
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) APRIL 09/95				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 111 PENN STREET, BALTIMORE, MARYLAND 21201										
31. DATE FILED (Month, Day, Year) APR 12 1995		32. REGISTRAR'S SIGNATURE 								

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13891

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) CLARA MILDRED THOMPSON				2. DATE OF DEATH MONTH DAY YEAR Apr 11 1995		3. TIME OF DEATH 2:30 am	
4. SOCIAL SECURITY NUMBER 041-22-9042		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 85 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 4, 1909	
8. BIRTHPLACE (State or Foreign Country) New York				9a. FACILITY NAME (If not institution, give street and number) Saint Joseph Medical Center		9b. CITY, TOWN OR LOCATION OF DEATH Towson, Maryland	
9c. COUNTY OF DEATH Baltimore				10a. STATE Maryland		10b. COUNTY Harford	
10c. CITY, TOWN OR LOCATION Joppatowne				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 604 A Harborside Drive	
10f. ZIP CODE 21085				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) College				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Home	
17. FATHER'S NAME (First, Middle, Last) Cashmere (nmn) Topolski				18. MOTHER'S NAME (First, Middle, Maiden Surname) Catherine (nmn) (u/k)			
19a. INFORMANT'S NAME (Type/Print) Edwin V. Thompson				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 604 A Harborside Drive, Joppatowne, Md. 21085			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Mt. St. Benedicts Cemetery 4/15/95 Bloomfield, CT		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Md. 21009			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → MULTIPLE ORGAN FAILURE DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>	
29c. LICENSE NUMBER D29306				29d. DATE SIGNED (Month, Day, Year) 4-11-95		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) A. ZALDWONDO, MD 7620 YORK RD. TOWSON, MD 21204	
31. DATE FILED (Month, Day, Year) APR 12 1995				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13892

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) William Douglas Webster, Sr.				2. DATE OF DEATH MONTH DAY YEAR April 18 1995		3. TIME OF DEATH 12:55 p. m.	
4. SOCIAL SECURITY NUMBER 272-09-1536		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 84 YRS.	7. DATE OF BIRTH (Month, Day, Year) May 6 1910		8. BIRTHPLACE (State or Foreign Country) West Virginia	
9a. FACILITY NAME (If not institution, give street and number) Garrett County Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Oakland		9c. COUNTY OF DEATH Garrett	
10a. STATE W. Va.		10b. COUNTY Preston		10c. CITY, TOWN OR LOCATION Kingwood		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 105 Julie St.				10f. ZIP CODE 26537		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 12 College (1-4 or 5+) 12		16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) salesman		17. KIND OF BUSINESS/INDUSTRY Insurance Agency			
17. FATHER'S NAME (First, Middle, Last) Charles D. Webster				18. MOTHER'S NAME (First, Middle, Maiden Surname) Sylvia Rinehart			
19a. INFORMANT'S NAME (Type/Print) W. Douglas Webster, Jr.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 508A Brandonville St. Terra Alta, WV 26764			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Aurora Cemetery 4-21-1995		20c. LOCATION — City or Town, State Aurora, W. Va.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Arthur H. Wright				22. NAME AND ADDRESS OF FACILITY Arthur H. Wright Funeral Home, Inc. 105 Highland Ave. Terra Alta, WV 26764			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Pulmonary Edema DUE TO (OR AS A CONSEQUENCE OF): Congestive Heart Failure DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUMBER D26568		29d. DATE SIGNED (Month, Day, Year) 4-19-95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Roger A. Lewis, M.D. 603B W. State Ave. Terra Alta, WV 26764							
31. DATE FILED (Month, Day, Year) APR 20 1995		32. REGISTRAR'S SIGNATURE Julia Anderson-Randall					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13893

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Ruby Alice Wiedrick				2. DATE OF DEATH MONTH April DAY 22 YEAR 1995		3. TIME OF DEATH 1:05 P M	
4. SOCIAL SECURITY NUMBER 212-22-5507		5. SEX 1 M 2 F	6. AGE (In yrs. last birthday) 67 YRS.	7. DATE OF BIRTH (Month, Day, Year) Oct. 4, 1927		8. BIRTHPLACE (State or Foreign Country) Pennsylvania	
9a. FACILITY NAME (If not institution, give street and number) Fallston General Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Fallston		9c. COUNTY OF DEATH Harford	
10a. STATE Maryland				10b. COUNTY Harford		10c. CITY, TOWN OR LOCATION Aberdeen	
10d. INSIDE CITY LIMITS? 1 YES 2 NO				10e. STREET AND NUMBER 348 Union Street			
10f. ZIP CODE 21001				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO		14. RACE — American Indian, Black, White, etc. White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Nursing		16b. KIND OF BUSINESS/INDUSTRY Medical			
17. FATHER'S NAME (First, Middle, Last) Raleigh Anderson				18. MOTHER'S NAME (First, Middle, Maiden Surname) Arminda Wells			
19a. INFORMANT'S NAME (Type/Print) Mr. Walter W. Wiedrick, Jr.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 348 Union Street, Aberdeen, Maryland 21001			
20a. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) R. A. Ferris & Co., Inc. 4/24		20c. LOCATION — City or Town, State West Chester, PA			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ruby R. Di Giovanni				22. NAME AND ADDRESS OF FACILITY Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. METASTATIC BREAST CANCER 2 YEARS DUE TO (OR AS A CONSEQUENCE OF): Sequitely ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify)					
27. MANNER OF DEATH 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 YES 2 NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Juan P. Edwards, MD				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) APRIL 22, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JOAN P. EDWARDS, MD 2112 BELAIR ROAD FALLSTON, MARYLAND 21047							
31. DATE FILED (Month, Day, Year) APR 24 1995		32. REGISTRAR'S SIGNATURE Juan P. Edwards					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13894

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MOSES WASHINGTON				2. DATE OF DEATH MONTH APRIL DAY 17 YEAR 1995		3. TIME OF DEATH 5:35^{PM}	
4. SOCIAL SECURITY NUMBER 215-52-7409		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 44 YRS.		7. DATE OF BIRTH (Month, Day, Year) MAY 8, 1950	
9a. FACILITY NAME (If not institution, give street and number) SOUTHERN MARYLAND HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH CLINTON		9c. COUNTY OF DEATH PRINCE GEORGE	
10a. STATE Maryland		10b. COUNTY Prince George		10c. CITY, TOWN OR LOCATION Aguasco		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER Rt 1 Box 206 Gen Del				10f. ZIP CODE 20608		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Skilled labor		16b. KIND OF BUSINESS/INDUSTRY Construction			
17. FATHER'S NAME (First, Middle, Last) Frederick Washington				18. MOTHER'S NAME (First, Middle, Maiden Surname) Eleanora Brown			
19a. INFORMANT'S NAME (Type/Print) Rosetta Savoy				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3002 Gallery Place, Waldorf MD 20602			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Resurrection		20c. LOCATION — City or Town, State Clinton MD		20d. DATE 4/24/95	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY Adams Funeral Home, Aguasco MD 20608			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Renal Failure Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. Cardiomyopathy b. Coronary artery disease c. Diabetes d. Hypertension Approximate Interval Between Onset and Death 3 weeks Yes							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CVA							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				29. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> M.D.				29c. LICENSE NUMBER 001923		29d. DATE SIGNED (Month, Day, Year) April 17, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) T. B. Fieldson M.D. 13600 Brandywine Rd Brandywine MD 20613							
31. DATE FILED (Month, Day, Year) APR 24 1995				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13895

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Margaret Estelle Ward				2. DATE OF DEATH MONTH DAY YEAR April 23, 1995		3. TIME OF DEATH 3:30A.M.	
4. SOCIAL SECURITY NUMBER 218-22-7449		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 78 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 2 1916	
9a. FACILITY NAME (If not institution, give street and number) 1316 Ridge Rd.				9b. CITY, TOWN OR LOCATION OF DEATH Westminster		9c. COUNTY OF DEATH Carroll	
10a. STATE Maryland		10b. COUNTY Carroll		10c. CITY, TOWN OR LOCATION Westminster		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 1316 Ridge Rd.				10f. ZIP CODE 21157		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife		16b. KIND OF BUSINESS/INDUSTRY Homemaker			
17. FATHER'S NAME (First, Middle, Last) Luther Randolph Campbell				18. MOTHER'S NAME (First, Middle, Maiden Surname) Myrtle Clara Davis			
19a. INFORMANT'S NAME (Type/Print) Anna M. Lilley				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1316 Ridge Rd. Westminster, Md. 21157			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Middletown Cemetery 4/25		20c. LOCATION — City or Town, State Middletown, Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Nancy K. Fletcher</i>				22. NAME AND ADDRESS OF FACILITY Fletcher Funeral Home 21157 254 E. Main St. Westminster, Md.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. METASTATIC CHOLANGIOCARCINOMA DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate Interval Between Onset and Death 1 month	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. NIDDM, CORONARY ARTERY DISEASE, hypertension						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) N/A		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 1 Thomas K. Galun MD				29c. LICENSE NUMBER D31660		29d. DATE SIGNED (Month, Day, Year) 4/24/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 1 THOMAS GALUN MD 542 WASHINGTON RD							
31. DATE FILED (Month, Day, Year) APR 24 1995				32. REGISTRAR'S SIGNATURE <i>David R. Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Etchel F. White
VOID

CERTIFICATE #

95-13896

SEE

CERTIFICATE #

95-15677

95 13897

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Dorothy H. Woodward</i>				2. DATE OF DEATH MONTH <i>April</i> DAY <i>13</i> YEAR <i>95</i>				3. TIME OF DEATH <i>9:40 AM</i>	
4. SOCIAL SECURITY NUMBER <i>086 18 8507</i>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>88</i> YRS.		IF UNDER 1 YEAR MONTHS _____ DAYS _____		IF UNDER 24 HRS. HOURS _____ MIN. _____	
7. DATE OF BIRTH (Month, Day, Year) <i>Aug. 22, 1906</i>				8. BIRTHPLACE (State or Foreign Country) <i>Massachusetts</i>					
9a. FACILITY NAME (If not institution, give street and number) <i>Holy Cross Hospital</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Silver Spring</i>				9c. COUNTY OF DEATH <i>Montgomery</i>	
10a. STATE <i>Maryland</i>				10b. COUNTY <i>Montgomery</i>		10c. CITY, TOWN OR LOCATION <i>Silver Spring</i>			
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO									
10e. STREET AND NUMBER <i>8505 Springvale Road</i>				10f. ZIP CODE <i>20910</i>				10g. CITIZEN OF WHAT COUNTRY? <i>United States</i>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>—</i>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Homemaker</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Own Home</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Harry Halsey</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>not available</i>					
19a. INFORMANT'S NAME (Type/Print) <i>Michael J. Zambito</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>8800 Eskridge Court, Gaithersburg, MD 20879</i>					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>April 17, 1995</i> <i>Riverview Cemetery</i>		20c. LOCATION — City or Town, State <i>Charlottesville, Virginia</i>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> M00689				22. NAME AND ADDRESS OF FACILITY <i>Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave., Bethesda, Maryland 20814</i>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Respiratory Failure</i> Approximate Interval Between Onset and Death <i>minutes</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. <i>Chronic obstructive pulmonary disease</i> years <i>years</i> b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Hip Fracture; CHF; aspiration pneumonia</i>								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO									
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <i>Feb 23 95</i>		28b. TIME OF INJURY <i>— M</i>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED <i>Fall</i>	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <i>Nursing Home</i>		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <i>3000 McConnaughey Ave. Bethesda</i>							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John Scudder MD</i>				29c. LICENSE NUMBER <i>D08546</i>		29d. DATE SIGNED (Month, Day, Year) <i>April 15 95</i>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>John Scudder 8218 Wisconsin Ave Bethesda</i>									
31. DATE FILED (Month, Day, Year) <i>APR 19 1995</i>		32. REGISTRAR'S SIGNATURE <i>John Scudder-Randall</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020


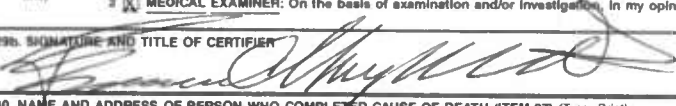
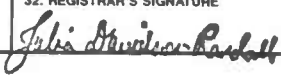
DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13898

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) John Matthew Weidman				2. DATE OF DEATH MONTH DAY YEAR April 14, 1995		3. TIME OF DEATH 12:25 P M	
4. SOCIAL SECURITY NUMBER 578-09-8801		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 87 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) May 25, 1907	
8. BIRTHPLACE (State or Foreign Country) Washington D.C.				9a. FACILITY NAME (If not institution, give street and number) Holy Cross Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring	
9c. COUNTY OF DEATH Montgomery				10a. STATE Maryland		10b. COUNTY Montgomery	
10c. CITY, TOWN OR LOCATION Silver Spring				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 237 Dale Drive	
10f. ZIP CODE 20910				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1942-1945				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Mailroom Foreman		16b. KIND OF BUSINESS/INDUSTRY Newspaper	
17. FATHER'S NAME (First, Middle, Last) Jacob Weidman				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mamie Specht			
19a. INFORMANT'S NAME (Type/Print) Josephine R. Weidman				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 237 Dale Drive Silver Spring, Maryland 20910			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gate of Heaven Cemetery 4/17/95		20c. LOCATION — City or Town, State Silver Spring, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd. W. Sil. Spr. MD 20901			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pneumonia DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. Quadriparesis DUE TO (OR AS A CONSEQUENCE OF): c. Anemia DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D07099		29d. DATE SIGNED (Month, Day, Year) April 18, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Francis C. Mayle, Jr., M.D. 10215 Fernwood Road #301 Bethesda, MD 20817							
31. DATE FILED (Month, Day, Year) APR 19 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13899

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) William Francis Whelan				2. DATE OF DEATH MONTH April DAY 17 YEAR 1995		3. TIME OF DEATH 5:10 P M	
4. SOCIAL SECURITY NUMBER 288-07-0041		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 87 YRS.	7. DATE OF BIRTH (Month, Day, Year) Nov. 2, 1907	8. BIRTHPLACE (State or Foreign Country) Massachusetts		
9a. FACILITY NAME (If not institution, give street and number) Circle Manor Nursing Home				9b. CITY, TOWN OR LOCATION OF DEATH Kensington		9c. COUNTY OF DEATH Montgomery	
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Kensington		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 4223 Everett Street				10f. ZIP CODE 20895		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Senior Technician		16b. KIND OF BUSINESS/INDUSTRY Business Machines			
17. FATHER'S NAME (First, Middle, Last) Philip Francis Whelan				18. MOTHER'S NAME (First, Middle, Maiden Surname) Margaret Whelan			
19a. INFORMANT'S NAME (Type/Print) Paula A. Warren				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4223 Everett Street, Kensington, MD 20895			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gate of Heaven Cemetery 4/20/95		20c. LOCATION — City or Town, State Silver Spring, Maryland		20d. DATE 4/20/95	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Paula A. Warren</i>				22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd.W. Sil.Spr.MD 20901			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Recurrent Respiration Pneumonia DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death 3 Mos.
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Obstructive Lung Disease							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. DESCRIBE HOW INJURY OCCURRED			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Barry Rosenbaum</i>				29c. LICENSE NUMBER D09834		29d. DATE SIGNED (Month, Day, Year) April 17, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Barry Rosenbaum, M.D. 3720 Farragut Ave., Kensington, MD 20895							
31. DATE FILED (Month, Day, Year) APR 20 1995				32. REGISTRAR'S SIGNATURE <i>John Davidson Russell</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

25

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13900

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Warren W. Waldron, Jr.				2. DATE OF DEATH MONTH April DAY 19 YEAR 1995				3. TIME OF DEATH 9:45 A M					
4. SOCIAL SECURITY NUMBER 577-38-9279		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 66 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) July 3, 1928		8. BIRTHPLACE (State or Foreign Country) Pennsylvania		
9a. FACILITY NAME (If not institution, give street and number) Holy Cross Hospital					9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring				9c. COUNTY OF DEATH Montgomery				
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Rockville				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO					
10e. STREET AND NUMBER 4807 Eades Street				10f. ZIP CODE 20853				10g. CITIZEN OF WHAT COUNTRY? USA					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Engineer				16b. KIND OF BUSINESS/INDUSTRY Nat'l. Park & Planning Comm					
17. FATHER'S NAME (First, Middle, Last) Warren W. Waldron, Sr.						18. MOTHER'S NAME (First, Middle, Maiden Surname) Dorothy Smith							
19a. INFORMANT'S NAME (Type/Print) Annie Laura Waldron						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4807 Eades Street, Rockville, Maryland 20853							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Parklawn Memorial Park 4/21				20c. LOCATION — City or Town, State Rockville, Maryland					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Thomas Guyon</i>				22. NAME AND ADDRESS OF FACILITY Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland 20904									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>CONGESTIVE HEART FAILURE</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>CORONARY ARTERY DISEASE</u> DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. <u>EMPHYSEMA</u> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST										Approximate interval between Onset and Death DAYS YEARS YEARS			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>										24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED					
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Allen A. Oboler</i>						29c. LICENSE NUMBER B93547		29d. DATE SIGNED (Month, Day, Year) 4/19/95					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Allen A. Oboler, M.D. 8830 Cameron Street, Silver Spring, Maryland 20910													
31. DATE FILED (Month, Day, Year) APR 21 1995				32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

10

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13901

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) REDA JEAN WARRENER				2. DATE OF DEATH MONTH DAY YEAR April 27, 1995				3. TIME OF DEATH 9:35 a.m.	
4. SOCIAL SECURITY NUMBER 215-34-0094		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 58 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) March 19, 1937	
8a. FACILITY NAME (If not institution, give street and number) GREATER BALTIMORE MEDICAL CENTER				8b. CITY, TOWN OR LOCATION OF DEATH TOWSON				8c. COUNTY OF DEATH BALTIMORE	
10a. STATE Maryland				10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Baltimore			
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 744 Edmondson Ave.				10f. ZIP CODE 21228	
10g. CITIZEN OF WHAT COUNTRY? U.S.A.				11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced				12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+) College (1-4 or 5+)	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife				16b. KIND OF BUSINESS/INDUSTRY Domestic				17. FATHER'S NAME (First, Middle, Last) Hurley Powers	
18. MOTHER'S NAME (First, Middle, Maiden Surname) Nancy Collins				19a. INFORMANT'S NAME (Type/Print) Donald Warrener, Jr.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14503 Thornton Rd., Sparks, MD 21152	
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Stablers Cemetery April 30, 1995				20c. LOCATION — City or Town, State Parkton, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>J.J. Hartenstein</i>				22. NAME AND ADDRESS OF FACILITY J.J. Hartenstein Mortuary, Inc. 24 Second St., New Freedom, PA 17349				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Colon Cancer Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>				25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>Paul Celano MD</i>	
29c. LICENSE NUMBER D30929				29d. DATE SIGNED (Month, Day, Year) 4/27/95				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) PAUL CELANO, MD. 6569 N. Charles St. BALTIMORE MD 21204	
31. DATE FILED (Month, Day, Year) MAY 03 1995				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Amended #1,

95 13902




1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) JAMES EDWARD WOOD				2. DATE OF DEATH MONTH APRIL DAY 6 YEAR 1995		3. TIME OF DEATH 0230			
4. SOCIAL SECURITY NUMBER 241-24-1720		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 71 YRS.		7. DATE OF BIRTH (Month, Day, Year) Sept. 18, 1923		8. BIRTHPLACE (State or Foreign Country) N. Carolina	
9a. FACILITY NAME (If not institution, give street and number) University of Maryland Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore			9c. COUNTY OF DEATH Baltimore		
10a. STATE Maryland				10b. COUNTY Washington		10c. CITY, TOWN OR LOCATION Hagerstown		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 148 Plantation Drive				10f. ZIP CODE 21740		10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES W.W. II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 0		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Master Plumber			15b. KIND OF BUSINESS/INDUSTRY Plumbing Contractor				
17. FATHER'S NAME (First, Middle, Last) Herbert Wood				18. MOTHER'S NAME (First, Middle, Maiden Surname) Bessie Barefoot					
19a. INFORMANT'S NAME (Type/Print) Otsy M. Wood				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 148 Plantation Dr. Hagerstown, Maryland 21740					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Germantown Baptist Church 4-8-95		20c. LOCATION — City or Town, State Germantown, Maryland					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 21740					
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → CARONARY ARTERY DISEASE DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. IDIOPATHIC PULMONARY FIBROSIS DUE TO (OR AS A CONSEQUENCE OF): c. PROSTATE CANCER DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER RESIDENT		29d. DATE SIGNED (Month, Day, Year) 4/6/95			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ANDREW MYERS 22. S. GREENE ST BALTIMORE, MD 21201									
31. DATE FILED (Month, Day, Year) APR 9 1995				32. REGISTRAR'S SIGNATURE 					

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13903

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last) MARY L WILLIAMS				2. DATE OF DEATH MONTH DAY YEAR April 18, 1995				3. TIME OF DEATH 12: 10 P. M	
4. SOCIAL SECURITY NUMBER 220-18-0603		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 70 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) 11-2-1924	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) 16735 Hampton Road				9b. CITY, TOWN OR LOCATION OF DEATH Williamsport	
9c. COUNTY OF DEATH Washington				10a. STATE Maryland				10b. COUNTY Washington	
10c. CITY, TOWN OR LOCATION Williamsport				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 16735 Hampton Road	
10f. ZIP CODE 21795				10g. CITIZEN OF WHAT COUNTRY? U.S.A.				11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 years College (1-4 or 5+) College				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Executive Secretary				16b. KIND OF BUSINESS/INDUSTRY Aircraft Mfg.	
17. FATHER'S NAME (First, Middle, Last) Clarence E. Brewer				18. MOTHER'S NAME (First, Middle, Maiden Surname) Hazel Forsythe				19a. INFORMANT'S NAME (Type/Print) Samuel G. Williams	
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16735 Hampton Road Williamsport, Maryland 21795				20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Rest Haven Cemetery 4-21-1995	
20c. LOCATION — City or Town, State Hagerstown, Maryland				21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Douglas A. Fiery</i>				22. NAME AND ADDRESS OF FACILITY Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown, Maryland	
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cerebral infarction Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. Cerebral infarction DUE TO (OR AS A CONSEQUENCE OF): b. Arteriosclerosis of lung DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):									Approximate Interval Between Onset and Death 3 months 10 months
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Arteriosclerosis of heart, type II Hypertension									24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Edson B. Moody</i>				29c. LICENSE NUMBER 107587				29d. DATE SIGNED (Month, Day, Year) 4/18/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Edson B. Moody 1190 Mt. Aetna Road Hagerstown, Maryland 21740									
31. DATE FILED (Month, Day, Year) APR 20 1995		32. REGISTRAR'S SIGNATURE <i>John A. Miller</i>							

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13904

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>LYMAN C WHITTAKER</i> Lyman C. Whittaker				2. DATE OF DEATH <i>4/15/95</i>		3. TIME OF DEATH <i>05:34</i>	
4. SOCIAL SECURITY NUMBER <i>220-30-1365</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>76</i> YRS.		7. DATE OF BIRTH <i>5/11/18</i>	
8. BIRTHPLACE (State or Foreign Country) Massachusetts				9a. FACILITY NAME (If not institution, give street and number) Anne Arundel Medical Center		9b. CITY, TOWN OR LOCATION OF DEATH Annapolis	
9c. COUNTY OF DEATH Anne Arundel				10a. STATE MD		10b. COUNTY Anne Arundel	
10c. CITY, TOWN OR LOCATION Annapolis				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 1656 Chinford Trail	
10f. ZIP CODE 21401				10g. CITIZEN OF WHAT COUNTRY? United States		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>6</i> College (1-4 or 5+) <i>6</i>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Captain		16b. KIND OF BUSINESS/INDUSTRY United States Army	
17. FATHER'S NAME (First, Middle, Last) William Whittaker				18. MOTHER'S NAME (First, Middle, Maiden Surname) Bertha Tryon			
19a. INFORMANT'S NAME (Type/Print) Gertrude M. Whittaker				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1656 Chinford Trail Annapolis, MD 21401			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Hillcrest Cemetery 4/18/95</i>		20c. LOCATION — City or Town, State <i>Annapolis, Maryland</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <i>John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Respiratory Arrest</i>							
a. DUE TO (OR AS A CONSEQUENCE OF):							
b. <i>Pneumonia</i> DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Intertrochanteric fracture, Rt hip</i>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year) <i>3/31/95</i>		28b. TIME OF INJURY <i>PM</i>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED <i>Fell from chair</i>			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <i>Home</i>				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <i>D12452</i>		29d. DATE SIGNED (Month, Day, Year) <i>4/15/95</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>900 Bestgate Rd, Annapolis, Md 21401</i>							
31. DATE FILED (Month, Day, Year) APR 19 1995				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13905

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Blanche Novalee Walton				2. DATE OF DEATH MONTH DAY YEAR Apr 11 1995		3. TIME OF DEATH 3:45PM M	
4. SOCIAL SECURITY NUMBER 206-12-0319		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 70 YRS.		7. DATE OF BIRTH (Month, Day, Year) 3-8-25	
9a. FACILITY NAME (If not institution, give street and number) Calvert Manor Nursing Home				9b. CITY, TOWN OR LOCATION OF DEATH Rising Sun		9c. COUNTY OF DEATH Cecil	
RESIDENCE OF DECEDENT							
10a. STATE PA		10b. COUNTY Chester		10c. CITY, TOWN OR LOCATION Oxford		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 901 Catamount Rd.				10f. ZIP CODE 19363		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College		18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Dairy Farmer		16b. KIND OF BUSINESS/INDUSTRY Agriculture			
17. FATHER'S NAME (First, Middle, Last) Cecil Fletcher				18. MOTHER'S NAME (First, Middle, Maiden Surname) Bertha Sheffield			
19a. INFORMANT'S NAME (Type/Print) Sandra G. Jennings				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arbour Court Nottingham, PA 19362			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Beulah Baptist Cemetery 4-14-95 Russellville, PA		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Edward L. Collins</i>				22. NAME AND ADDRESS OF FUNERAL HOME Edward L. Collins Funeral Home, Inc. 86 Pine St. Oxford, PA 19363			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. METASTATIC CARCINOMA OF BREAST DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death YRS
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERTENSION, FRACTURE RIGHT HIP							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Suresh Dhanjani</i>				29c. LICENSE NUMBER D45344		29d. DATE SIGNED (Month, Day, Year) 4/12/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SURESH DHANJANI, MD, 20 CRAIGTOWN RD, PERRYVILLE, MD 21903							
31. DATE FILED (Month, Day, Year) APR 17 1995				32. REGISTRAR'S SIGNATURE <i>J. B. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.


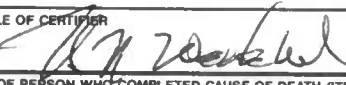

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13906

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Myrtle Marie YATES				2. DATE OF DEATH MONTH April DAY 15, YEAR 1995				3. TIME OF DEATH 3:00 p. M							
4. SOCIAL SECURITY NUMBER 245-07-4462		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 75 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) April 12, 1920		8. BIRTHPLACE (State or Foreign Country) N. C.			
9a. FACILITY NAME (If not institution, give street and number) 11204 Pepperbush Circle						9b. CITY, TOWN OR LOCATION OF DEATH Hagerstown				9c. COUNTY OF DEATH Washington					
10a. STATE Maryland				10b. COUNTY Washington				10c. CITY, TOWN OR LOCATION Hagerstown				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 11204 Pepperbush Circle						10f. ZIP CODE 21740				10g. CITIZEN OF WHAT COUNTRY? USA					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: white					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 3 College (1-4 or 5+) 0				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) homemaker				16b. KIND OF BUSINESS/INDUSTRY her own home							
17. FATHER'S NAME (First, Middle, Last) J. T. Twiddy						18. MOTHER'S NAME (First, Middle, Maiden Surname) Alice Tweedy									
19a. INFORMANT'S NAME (Type/Print) John H. Yates						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21334 Twin Springs Dr., Smithsburg, Md. 21783									
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Cedar Lawn Memorial Park 4-19-95				20c. LOCATION — City or Town, State Hagerstown, Md.							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 						22. NAME AND ADDRESS OF FACILITY MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cancer of the lung for 4 years, with metatasis DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.												Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>															
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
29b. SIGNATURE AND TITLE OF CERTIFIER 						29c. LICENSE NUMBER D 11246				29d. DATE SIGNED (Month, Day, Year) 4/18/95					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Howard N. Weeks, M.D. 580 Northern Ave., Hagerstown, Maryland 21742															
31. DATE FILED (Month, Day, Year) APR 18 1995						32. REGISTRAR'S SIGNATURE 									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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95 13907

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Joseph A. Alagna Jr.				2. DATE OF DEATH MONTH 5 DAY 2 YEAR 95				3. TIME OF DEATH 7:35 P M	
4. SOCIAL SECURITY NUMBER 213-20-4119		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 69 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS. HOURS 0 MIN. 0	
7. DATE OF BIRTH (Month, Day, Year) 10 5 25				8. BIRTHPLACE (State or Foreign Country) Maryland					
9a. FACILITY NAME (If not institution, give street and number) VA Medical Center				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore				9c. COUNTY OF DEATH N/A	
RESIDENCE OF DECEDENT									
10a. STATE MD		10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 338 South Oldham Street				10f. ZIP CODE 21224		10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11th College (1-4 or 5+) College				15e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Supply Supervisor		16b. KIND OF BUSINESS/INDUSTRY Trophy			
17. FATHER'S NAME (First, Middle, Last) Joseph Albert Alagna Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Frances Culotta					
19a. INFORMANT'S NAME (Type/Print) JoAnne M. Valcourt				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 338 S. Oldham St., Balto., MD 21224					
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) New Cathedral Cemetery 5/6/95		DATE 5/6/95		20c. LOCATION — City or Town, State Balto., MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Charles S. Zeiler				22. NAME AND ADDRESS OF FACILITY Charles S. Zeiler & Son Inc. 6224 Eastern Ave., Balto., MD					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Ventricular Fibrillation DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Multi-system Organ Failure DUE TO (OR AS A CONSEQUENCE OF): Congestive Heart Failure DUE TO (OR AS A CONSEQUENCE OF):								Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Congestive Heart Failure								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER Lois Killewich				29c. LICENSE NUMBER D43615		29d. DATE SIGNED (Month, Day, Year) 5-5-95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Lois Killewich 109 GREENE ST. BALTIMORE MD 21201									
31. DATE FILED (Month, Day, Year) MAY 08 1995		32. REGISTRAR'S SIGNATURE John [Signature]							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

5+1

MADE IN U.S.A. 100% COTTON

95 13908

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Laurae Ha A. Anderson</i>				2. DATE OF DEATH MONTH <i>May</i> DAY <i>4</i> YEAR <i>1995</i>				3. TIME OF DEATH <i>5:23 A. M.</i>	
4. SOCIAL SECURITY NUMBER <i>215-22-7640</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) YRS. MONTHS DAYS		7. DATE OF BIRTH (Month, Day, Year) <i>May 19, 1916</i>		8. BIRTHPLACE (State or Foreign Country) <i>Id</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Maryland Manor N.H.</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Glen Burnie</i>				9c. COUNTY OF DEATH <i>Anne Arundel</i>	
10a. STATE <i>Md</i>		10b. COUNTY <i>Anne Arundel</i>		10c. CITY, TOWN OR LOCATION <i>Glen Burnie</i>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <i>7575 E. Howard Rd</i>				10f. ZIP CODE <i>21061</i>		10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>Black</i>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12th grade</i> College (1-4 or 5+) <i>1yr</i>				15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Dietitian</i>		15b. KIND OF BUSINESS/INDUSTRY <i>State of md</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Taylor 2 Carey</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Maudie Howard</i>					
19a. INFORMANT'S NAME (Type/Print) <i>Felishia Little</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>101 Saint Charles Rd Glen Burnie, Md 21332</i>					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>London Park Cem. 5/4/95</i>		20c. LOCATION — City or Town, State <i>Balto, md</i>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Alvin B. Scott</i>				22. NAME AND ADDRESS OF FACILITY <i>March F.H. West 4300 Wabash Ave Balto, Md 21215</i>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Hypertensive Cardiovascular Disease</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <i>Hypertensive Cardiovascular Disease</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>Congestive Heart Failure</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i>Atrial Fibrillation</i> DUE TO (OR AS A CONSEQUENCE OF): d. <i>Hypothyroidism</i>									Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Old Cerebrovascular Accident</i>									24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO									25. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									29c. LICENSE NUMBER <i>D14160</i>
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Harjit Singh, M.D. (Attending Physician)</i>									29d. DATE SIGNED (Month, Day, Year) <i>05/05/95</i>
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Harjit Singh, M.D. 5410-A Ritchie Highway Baltimore, Md. 21225</i>									
31. DATE FILED (Month, Day, Year) <i>MAY 08 1995</i>		32. REGISTRAR'S SIGNATURE <i>John Anderson</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.



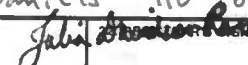
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13909

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) GARFIELD ALLENDER SR.				2. DATE OF DEATH MONTH MAY DAY 3 YEAR 1995		3. TIME OF DEATH 6:30 a M	
4. SOCIAL SECURITY NUMBER 217-12-3333		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 69 YRS.		7. DATE OF BIRTH MONTH 5 DAY 25 YEAR 1925	
9a. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY		9c. COUNTY OF DEATH N/A	
10a. STATE MARYLAND		10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION BALTIMORE		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 1225 N. POTOMAC STREET				10f. ZIP CODE 21213		10g. CITIZEN OF WHAT COUNTRY? U.S.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES W.W.II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) 		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) TRUCK DRIVER		16b. KIND OF BUSINESS/INDUSTRY TRUCKING BUSINESS			
17. FATHER'S NAME (First, Middle, Last) ERNEST ALLENDER				18. MOTHER'S NAME (First, Middle, Maiden Surname) MARION SHARP			
19a. INFORMANT'S NAME (Type/Print) ESSIE ALLENDER				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1225 N. POTOMAC ST. BALTIMORE MARYLAND 21213			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GREEN MOUNT 5-6		20c. LOCATION — City or Town, State BALTIMORE, MARYLAND			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY IRVIN CARROLL 1712W. NORTH AVENUE			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cerebrovascular Accident DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. c. d. GI Bleed						Approximate interval Between Onset and Death 5 days 10 days	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) N/A		28b. TIME OF INJURY N/A M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED N/A		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) N/A		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) N/A	
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER  M.D.				29c. LICENSE NUMBER M3600		29d. DATE SIGNED (Month, Day, Year) 5/3/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Paul Daniels 110 Tower Johns Hopkins Hospital, Baltimore md 21205							
31. DATE FILED (Month, Day, Year) MAY 08 1995 							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OF THE FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

REG. NO.

DHMH-18 Rev 1/99

95 13911

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) LILLIAN G BROSEKER				2. DATE OF DEATH MONTH DAY YEAR Apr 27 1995		3. TIME OF DEATH 1:10 pm	
4. SOCIAL SECURITY NUMBER 217-07-9376		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 89 YRS.		7. DATE OF BIRTH (Month, Day, Year) OCT 6, 1905	
8. BIRTHPLACE (State or Foreign Country) MARYLAND				9a. FACILITY NAME (If not institution, give street and number) Saint Joseph Medical Center		9b. CITY, TOWN OR LOCATION OF DEATH Towson, Maryland	
9c. COUNTY OF DEATH Baltimore				10a. STATE Md		10b. COUNTY BALTO.	
10c. CITY, TOWN OR LOCATION Perry Hall				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 4 DUNHAVEN Place 1B	
10f. ZIP CODE 21236				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) —				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) BUYER		16b. KIND OF BUSINESS/INDUSTRY RETAIL	
17. FATHER'S NAME (First, Middle, Last) LOUIS HILTZ				18. MOTHER'S NAME (First, Middle, Maiden Surname) LAURA Miller Whetmann			
19a. INFORMANT'S NAME (Type/Print) GORDON H. Broseker				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2509 Burrridge Rd Balto. Md. 21234			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Parkwood 5/1/95		20c. LOCATION — City or Town, State Parkville, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Robert W. Jones</i>				22. NAME AND ADDRESS OF FACILITY EVANS Chapel of Memories 8800 HARFORD Rd Balto. Md 21234			
23. PART I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → PNEUMONIA							
DUE TO (OR AS A CONSEQUENCE OF):							
URINARY TRACT INFECTION							
DUE TO (OR AS A CONSEQUENCE OF):							
CHRONIC CONGESTIVE HEART FAILURE							
DUE TO (OR AS A CONSEQUENCE OF):							
Approximate interval Between Onset and Death 7 DAYS							
Approximate interval Between Onset and Death 7 DAYS							
Approximate interval Between Onset and Death 4 YEARS							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Natividad D. de Leon, M.D.</i>				29c. LICENSE NUMBER D 19508		29d. DATE SIGNED (Month, Day, Year) April 27, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) NATIVIDAD D. DE LEON, M.D., 7620 YORK ROAD TOWSON, MARYLAND 21204							
31. DATE FILED (Month, Day, Year) MAY 08 1995				32. REGISTRAR'S SIGNATURE <i>John D. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL
TO THE FUNERAL HOME
TO THE COUNTY HEALTH DEPT.
TO THE STATE DEPT. OF HEALTH AND MENTAL HYGIENE
IMPORTANT: If item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DEPARTMENT OF HEALTH

NEW YORK

STATE

CHRONIC CONGESTIVE HEART FAILURE

PRIMARY TRACT INFECTION

PNEUMONIA

NATIVIDAD O. DE LEON, M.D., 1820 YORK ROAD, TOWSON, MARYLAND 21204

DATE

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) CHARLES BALINT				2. DATE OF DEATH MONTH APRIL DAY 30 YEAR 1995		3. TIME OF DEATH 10:30 A M	
4. SOCIAL SECURITY NUMBER 151 09 5169		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 77 YRS.		7. DATE OF BIRTH (Month, Day, Year) 11/24/17	
8. BIRTHPLACE (State or Foreign Country) New York				9a. FACILITY NAME (If not Institution, give street and number) St. Agnes Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City	
9c. COUNTY OF DEATH n/a				10a. STATE Md.		10b. COUNTY Anne Arundel	
10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 201 Ninth Avenue	
10f. ZIP CODE 21225				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR OATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 years College (1-4 or 5+) 2 years		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) steel worker		16b. KIND OF BUSINESS/INDUSTRY steel			
17. FATHER'S NAME (First, Middle, Last) Charles S. Balint				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Bordash			
19a. INFORMANT'S NAME (Type/Print) Mildred C. Balint				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 201 9th Ave. Baltimore Md. 21225			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Holy Cross Cemetery 5/3/95		20c. LOCATION — City or Town, State Baltimore Md. 21225			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Richard D. Gonne</i>				22. NAME AND ADDRESS OF FACILITY 4001 Ritchie Hwy. Baltimore Md. 21225			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. Pulmonary embolus				Approximate Interval Between Onset and Death minutes	
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. sudden ulcer with hemorrhage				2 days	
		c. atrial fibrillation				2 days	
		d.					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. unexplained elevated liver enzymes							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dan E. Birchess MD</i>				29c. LICENSE NUMBER 022114		29d. DATE SIGNED (Month, Day, Year) April 30, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DAMIAN E. BIRCHESS MD, 5411 OLD FREDERICK RD, SUITE 18, BALTIMORE, MD, 21229							
31. DATE FILED (Month, Day, Year) MAY 08 1995		32. REGISTRAR'S SIGNATURE <i>John D. ...</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.



TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13913

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JOSEPH BARNES				2. DATE OF DEATH MONTH 4 DAY 28 YEAR 95		3. TIME OF DEATH 2:15 P M	
4. SOCIAL SECURITY NUMBER 214-12-9511		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 96 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 12 22 1898	
8. BIRTHPLACE (State or Foreign Country) NORTH CAROLINA				9. FACILITY NAME (If not institution, give street and number) IRVINGTON KNOLLS NURSING CENTER		10. CITY, TOWN OR LOCATION OF DEATH BALTIMORE	
11. COUNTY OF DEATH N/A				12. RESIDENCE OF DECEDENT 10a. STATE MARYLAND		10b. COUNTY N/A	
10c. CITY, TOWN OR LOCATION BALTIMORE				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 1628 GWYNN FALLS PARKWAY	
10f. ZIP CODE 21217				10g. CITIZEN OF WHAT COUNTRY? U.S.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) MINISTER		16b. KIND OF BUSINESS/INDUSTRY RELIGION	
17. FATHER'S NAME (First, Middle, Last) JOSEPH BARNES				18. MOTHER'S NAME (First, Middle, Maiden Surname) REBECCA KENT			
19a. INFORMANT'S NAME (Type/Print) FLORENCE BARNES				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2121 WINDSOR GARDEN LANE BALTIMORE MARYLAND			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MT. ZION 5-3		20c. LOCATION — City or Town, State BALTIMORE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY IRVIN CARROLL 1712 W. NORTH AVENUE			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Coronary artery disease</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>Senile Dementia</u> DUE TO (OR AS A CONSEQUENCE OF): c. <u>Cranio-pharyngeal dysphagia</u> DUE TO (OR AS A CONSEQUENCE OF): d. Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) N/A		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED N/A		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) N/A		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) N/A			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER  Attending physician				29c. LICENSE NUMBER D30115		29d. DATE SIGNED (Month, Day, Year) 5/2/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) T. Ohuokeh, 2600 Liberty Hts Ave Baltimore 21215							
31. DATE FILED MAY 08 1995							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



3

Submitted by [illegible] 10/1/17

95 13914

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Roland B. Brophy				2. DATE OF DEATH MONTH 5 DAY 6 YEAR 95		3. TIME OF DEATH 9:25 P.M.	
4. SOCIAL SECURITY NUMBER 219-22-9252		5. SEX 1 M 2 F		6. AGE (In yrs. last birthday) 66 YRS.		7. DATE OF BIRTH (Month, Day, Year) 03 28 29	
8. FACILITY NAME (If not institution, give street and number) B. Manner Health Care of Baltimore				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City		9c. COUNTY OF DEATH BALTIMORE CITY	
10a. STATE MARYLAND		10b. COUNTY BALTIMORE CITY		10c. CITY, TOWN OR LOCATION BALTIMORE		10d. INSIDE CITY LIMITS? 1 YES 2 NO	
10e. STREET AND NUMBER 1518 W. Pratt St				10f. ZIP CODE 21223		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9TH GRADE College (1-4 or 5+) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) TRUCK DRIVER		16b. KIND OF BUSINESS/INDUSTRY TRUCKING	
17. FATHER'S NAME (First, Middle, Last) JOHN LEROY BROPHY				18. MOTHER'S NAME (First, Middle, Maiden Surname) MARGARET CATHERINE COOK			
19a. INFORMANT'S NAME (Type/Print) MRS. LINDA ZORNES				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8423 ARBUTUS ROAD - PASADENA, MD 21122			
20a. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GLEN HAVEN CEMETERY		DATE 5/10		20c. LOCATION — City or Town, State GLEN BURNIE, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Jackie D. Shannon				22. NAME AND ADDRESS OF FACILITY HUBBARD FUNERAL HOME INC. 4107 WILKENS AVENUE-BALTIMORE, MD 21229			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Metastatic Small Cell Carcinoma of Lung Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death months
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Pneumonia							24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO		HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 ODA		26. PLACE OF DEATH (Check only one) OTHER: 4 Nursing Home 5 Residence 6 Other (Specify)			
27. MANNER OF DEATH 1 Natural 5 Pending Investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide		28a. DATE OF INJURY (Month, Day, Year) N/A		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 YES 2 NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER John Hunter Copeland MD				29c. LICENSE NUMBER D27034		29d. DATE SIGNED (Month, Day, Year) May 7, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John Hunter Copeland MD 5310 Old Court Road Suite 201 Randallstown MD 21133							
31. DATE FILED (Month, Day, Year) MAY 10 1995		32. REGISTRAR'S SIGNATURE John Hunter Copeland					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



CONFIDENTIAL - SECURITY INFORMATION

95 13915

Item # 2,19b Film # G 723 5-8-95 N.A. Per Funeral home

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) VERNA BATCHELDER.				2. DATE OF DEATH MONTH MAY DAY 3 YEAR 1995		3. TIME OF DEATH 5 P.	
4. SOCIAL SECURITY NUMBER 261-32-1473		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 74 YRS.		7. DATE OF BIRTH (Month, Day, Year) 05/01/1921	
9a. FACILITY NAME (If not institution, give street and number) Lorien Nursing Home				9b. CITY, TOWN OR LOCATION OF DEATH Columbia		9c. COUNTY OF DEATH Howard	
10a. STATE Maryland				10b. COUNTY Anne Arundel		10c. CITY, TOWN OR LOCATION Laurel	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 243 Federalburg South			
10f. ZIP CODE 20724				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Home			
17. FATHER'S NAME (First, Middle, Last) George Chambers				18. MOTHER'S NAME (First, Middle, Maiden Surname) Edith Harper			
19a. INFORMANT'S NAME (Type/Print) Richard Batchelder				19b. MAILING ADDRESS (Street and Number, or Rural Route Number, City or Town, State, Zip Code) 243 Federalburg Square, Laurel, Maryland 20724			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Baltimore-Washington Crematory 5/7		20c. LOCATION — City or Town, State Laurel, Maryland		21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>	
22. NAME AND ADDRESS OF FACILITY Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Laurel, Maryland 20707				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. SEPTIC SHOCK, PNEUMONIA Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. BEDRIDDEN STATE c. TERMINAL PARKINSON'S DISEASE d. + ALZHEIMER'S DISEASE			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>				25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Nomicide			
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER Frank Gross MD.		29c. LICENSE NUMBER D10344	
29d. DATE SIGNED (Month, Day, Year) MAY 4, 1995				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) FRANK GROSS MD 21001 N. COLUMBIA MD 21045			
31. DATE FILED (Month, Day, Year) MAY 08 1995				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

95 13916

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Kenneth R. Christley				2. DATE OF DEATH MONTH DAY YEAR May 4 1995		3. TIME OF DEATH 3:40 P.M.	
4. SOCIAL SECURITY NUMBER 212-76-3894		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 36 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) MAY 31, 1958	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) Perry Point VAMC		9b. CITY, TOWN OR LOCATION OF DEATH Perry Point	
9c. COUNTY OF DEATH Cecil				10a. STATE Maryland		10b. COUNTY Cecil	
10c. CITY, TOWN OR LOCATION Port Deposit				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 10 Sandy Brook Drive	
10f. ZIP CODE 21904				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1975-1976				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Cook		16b. KIND OF BUSINESS/INDUSTRY Restaurant	
17. FATHER'S NAME (First, Middle, Last) Frank Christley				18. MOTHER'S NAME (First, Middle, Maiden Surname) Violet Mae Stanley			
19a. INFORMANT'S NAME (Type/Print) Carol Sue Wright				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4 Pleasant View Church Rd. Port Deposit, MD 21904			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory, Inc. 05/05/95		20c. LOCATION — City or Town, State Baltimore, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE George E. MacNabb				22. NAME AND ADDRESS OF FACILITY Cremation Society of Maryland 299 Frederick Rd. Baltimore, MD 21228			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acquired Immune Deficiency Syndrome DUE TO (OR AS A CONSEQUENCE OF): Sequently ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. Hepatic Failure DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> 4 Nursing Home <input type="checkbox"/> 5 Residence <input type="checkbox"/> 6 Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER EUGENE CRAIG, MD				29c. LICENSE NUMBER MD D41608		29d. DATE SIGNED (Month, Day, Year) 5/4/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) EUGENE CRAIG, MD VAMC PERRY POINT, MD 21902							
31. DATE FILED (Month, Day, Year) MAY 08 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR AT THE PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13917

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) Arthur Chancellor				2. DATE OF DEATH MONTH May DAY 4 YEAR 1995		3. TIME OF DEATH 2:10 P.M.	
4. SOCIAL SECURITY NUMBER 213-14-2386		5. SEX 1 <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 88 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 4 13 1907	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) Sinai Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore	
9c. COUNTY OF DEATH N/A				10a. STATE Maryland		10b. COUNTY N/A	
10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 2525 W. Belvedere Avenue	
10f. ZIP CODE 21215				10g. CITIZEN OF WHAT COUNTRY? U.S.		11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEASED'S EDUCATION (Specify only highest grade completed) 12 Elementary/Secondary (0-12) College (1-4 or 5+)				16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Salesman		16b. KIND OF BUSINESS/INDUSTRY Retail	
17. FATHER'S NAME (First, Middle, Last) Arthur B. Chancellor				18. MOTHER'S NAME (First, Middle, Maiden Surname) Miriam O. Opie			
19a. INFORMANT'S NAME (Type/Print) Gail Graves				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2525 W. Belvedere Ave Baltimore, Maryland 21215			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) London 5-9 Baltimore		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE [Signature]				22. NAME AND ADDRESS OF FACILITY Irvin Carroll 1712 W. North Ave.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Sepsis (with bacteremia)							
DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. Aspiration							
DUE TO (OR AS A CONSEQUENCE OF):							
DUE TO (OR AS A CONSEQUENCE OF):							
DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) N/A		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED N/A		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) N/A		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) N/A		28g. DATE SIGNED (Month, Day, Year) May 4, 1995	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Laura J. Wiener				29c. LICENSE NUMBER A62402321LN9850		29d. DATE SIGNED (Month, Day, Year) May 4, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) LAURA J. WIENER SINAI HOSPITAL							
31. DATE FILED (Month, Day, Year) MAY 6 1995				32. REGISTRAR'S SIGNATURE [Signature]			

TO BE COMPLETED BY FUNERAL DIRECTOR

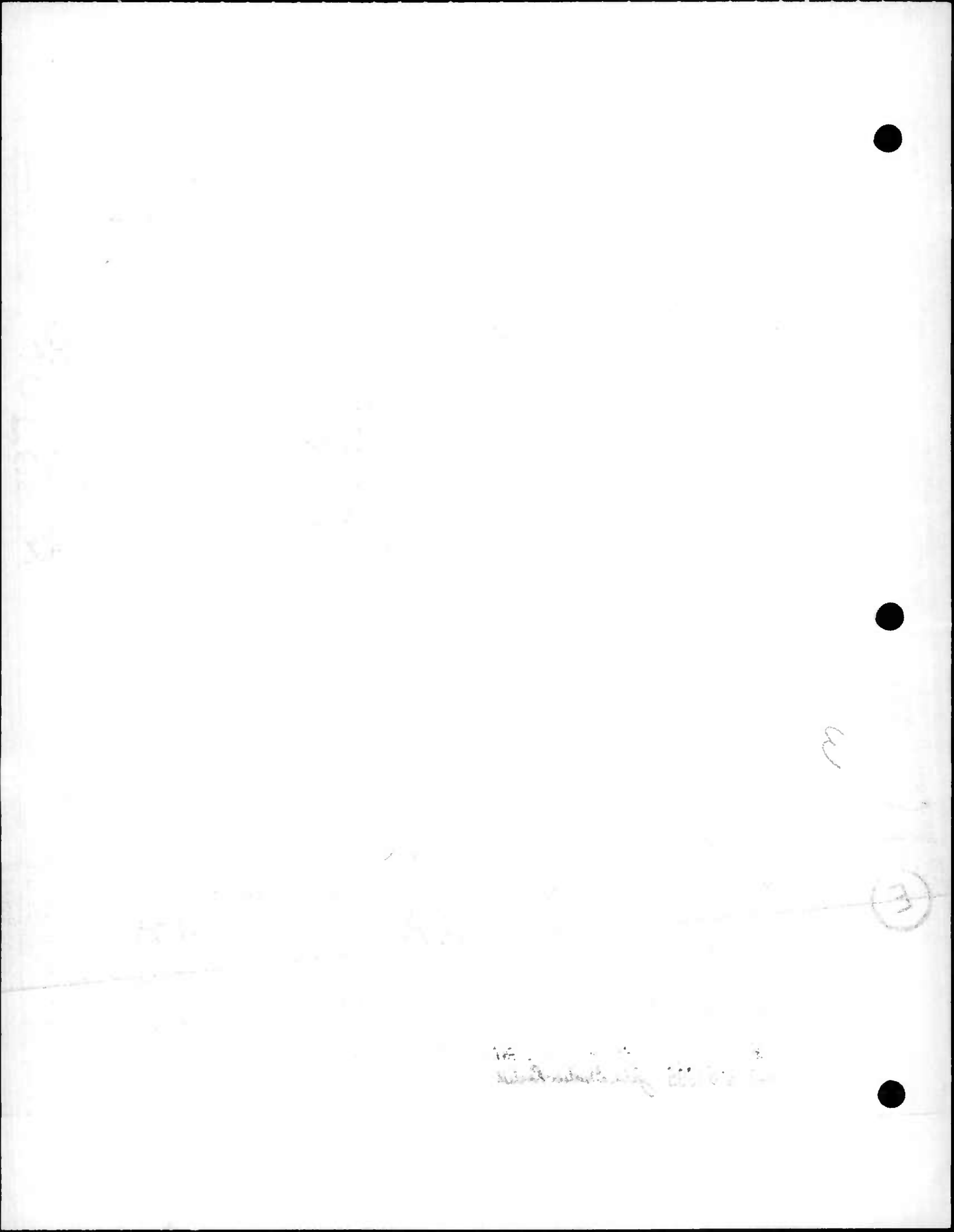
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) REBECCA CHAMBERLAIN Chamberlain				2. DATE OF DEATH MONTH APRIL DAY 30 YEAR 1995		3. TIME OF DEATH 8-24 A M	
4. SOCIAL SECURITY NUMBER 247-05-5807		5. SEX 1 M 2 F	6. AGE (in yrs. last birthday) 86 YRS.	7. DATE OF BIRTH (Month, Day, Year) May 25, 1908		8. BIRTHPLACE (State or Foreign Country) S.C.	
9a. FACILITY NAME (If not institution, give street and number) Harbor Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Balto		9c. COUNTY OF DEATH Balto	
RESIDENCE OF DECEDENT							
10a. STATE md		10b. COUNTY Balto		10c. CITY, TOWN OR LOCATION Balto		10d. INSIDE CITY LIMITS? 1 X YES 2 NO	
10e. STREET AND NUMBER 209 Bridgeview Rd				10f. ZIP CODE 21225		10g. CITIZEN OF WHAT COUNTRY? U.S.A	
11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify:		14. RACE — American Indian, Black, White, etc. Specify Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) NA				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) N/A		16b. KIND OF BUSINESS/INDUSTRY N/A	
17. FATHER'S NAME (First, Middle, Last) Ernest Miller				18. MOTHER'S NAME (First, Middle, Maiden Surname) Florence Miller			
19a. INFORMANT'S NAME (Type/Print) Linda Moore				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2538 Barnesley Place Balto, md 21244			
20a. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Clarrison Forest Vet 5/5/95		20c. LOCATION — City or Town, State Dwings Mills, Md			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Gladys Wane				22. NAME AND ADDRESS OF FACILITY Mark E. West 4300 Wabash Ave Balto, md 21215			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
a. ANOXIC ENCEPHALOPATHY.							
DUE TO (OR AS A CONSEQUENCE OF):							
b. CARDIAC ARREST							
DUE TO (OR AS A CONSEQUENCE OF):							
c. MYOCARDIAL INFARCTION							
DUE TO (OR AS A CONSEQUENCE OF):							
d. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE							
Approximate Interval Between Onset and Death 10 days 10 days 10 days 15 years							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. RENAL FAILURE. INSULIN DEPENDANT DIABETES MELLITUS							
24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 8 Other (Specify)					
27. MANNER OF DEATH 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 YES 2 NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Linda Pai				29c. LICENSE NUMBER AS 2441614-36		29d. DATE SIGNED (Month, Day, Year) APRIL 30 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SUDHA PAI, 7850-TI. AMERICAN CURLE, GLEN BURNIE - MD - 21060							
31. DATE FILED (Month, Day, Year) MAY 08 1995				32. REGISTRAR'S SIGNATURE John Andrew Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

LI

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13919

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Thelma L. Carpenter				2. DATE OF DEATH MONTH DAY YEAR May 04 1995		3. TIME OF DEATH 9:45 A M	
4. SOCIAL SECURITY NUMBER 218-01-0765		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 79 YRS.		7. DATE OF BIRTH (Month, Day, Year) SEP. 25-15	
9a. FACILITY NAME (If not institution, give street and number) 211 W. Hilltop Road		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH Anne Arundel			
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Anne Arundel		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 211 W. Hilltop Road				10f. ZIP CODE 21225		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 8th		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Home Maker		16b. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) Oscar William Winebrenner				18. MOTHER'S NAME (First, Middle, Maiden Surname) Edna Clayball			
19a. INFORMANT'S NAME (Type/Print) Harry Carpenter				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1094 Colony Ridge Road Odenton, Maryland 21113			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Cedar Hill Cemetery		DATE 5/8		20c. LOCATION — City or Town, State Baltimore, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Richard Gonce				22. NAME AND ADDRESS OF FACILITY George J. Gonce Funeral Home P.A. 4001 Ritchie Hwy. Baltimore, Md. 21225			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pneumonia DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate interval Between Onset and Death 2 wks
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Congestive Heart failure, carcinoma OF Breast DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Afroze Muneer MD				29c. LICENSE NUMBER D45105		29d. DATE SIGNED (Month, Day, Year) May 4, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Afroze Muneer 707 E. Fort Avenue Baltimore, Maryland 21230							
31. DATE FILED (Month, Day, Year) MAY 08 1995				32. REGISTRAR'S SIGNATURE John A. ...			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>CHRISTIANSEN, JOSEPH</u>				2. DATE OF DEATH MONTH <u>MAY</u> DAY <u>2</u> YEAR <u>1995</u>				3. TIME OF DEATH <u>5:50 P.M.</u>					
4. SOCIAL SECURITY NUMBER <u>472-50-9080</u>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <u>48</u> YRS.	IF UNDER 1 YEAR MONTHS <u> </u> DAYS <u> </u>		IF UNDER 24 HRS. HOURS <u> </u> MIN. <u> </u>		7. DATE OF BIRTH (Month, Day, Year) <u>June 16, 1946</u>		8. BIRTHPLACE (State or Foreign Country) <u>Minnesota</u>			
9a. FACILITY NAME (If not institution, give street and number) <u>Church Hospital</u>				9b. CITY, TOWN OR LOCATION OF DEATH <u>Baltimore City</u>				9c. COUNTY OF DEATH <u>N/A</u>					
10a. STATE <u>Maryland</u>		10b. COUNTY <u>Baltimore</u>		10c. CITY, TOWN OR LOCATION <u>Dundalk</u>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
10e. STREET AND NUMBER <u>106 Kinship Road</u>				10f. ZIP CODE <u>21222</u>				10g. CITIZEN OF WHAT COUNTRY? <u>United States</u>					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <u>Vietnam</u>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: <u> </u>				14. RACE — American Indian, Black, White, etc. Specify: <u>White</u>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u> </u> College (1-4 or 5+) <u>4 Years</u>				15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Lieutenant</u>				15b. KIND OF BUSINESS/INDUSTRY <u>Police Department</u>					
17. FATHER'S NAME (First, Middle, Last) <u>Arvid Christiansen</u>						18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Millie Gillie</u>							
19a. INFORMANT'S NAME (Type/Print) <u>Mrs. Denise J. Christiansen</u>						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>106 Kinship Road Dundalk, Maryland 21222</u>							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) <u> </u>				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Bel Air Mem. Gdns. 5/6/95</u>				DATE <u> </u>		20c. LOCATION — City or Town, State <u>Bel Air, Maryland</u>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>[Signature]</u>						22. NAME AND ADDRESS OF FACILITY <u>Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, MD 21222</u>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>a. PERIPHERAL CIRCULATORY FAILURE</u> DUE TO (OR AS A CONSEQUENCE OF): <u>b. SEPTIC SHOCK</u> DUE TO (OR AS A CONSEQUENCE OF): <u>c. ACUTE HEMORRHAGIC PANCREATITIS</u> DUE TO (OR AS A CONSEQUENCE OF): <u>d. </u> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST										Approximate Interval Between Onset and Death <u>18</u>			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>ACUTE RENAL FAILURE</u>										24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) <u> </u>									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year) <u> </u>		28b. TIME OF INJURY <u>M</u>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED <u> </u>			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <u> </u>						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <u> </u>							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER <u>VM Abhyankar MD</u>						29c. LICENSE NUMBER <u>D25027</u>		29d. DATE SIGNED (Month, Day, Year) <u>MAY 2, 1995</u>					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>CHURCH Hosp 100 N. Broadway Baltimore Md. 21231</u>													
31. DATE FILED (Month, Day, Year) <u>MAY 08 1995</u>				32. REGISTRAR'S SIGNATURE <u>[Signature]</u>									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.




TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13921

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) LESTER DOBIE				2. DATE OF DEATH MONTH 5 DAY 5 YEAR 95		3. TIME OF DEATH 10:48P	
4. SOCIAL SECURITY NUMBER 218-74-8051		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 34 YRS.		7. DATE OF BIRTH (Month, Day, Year) 11 30 61	
8. BIRTHPLACE (State or Foreign Country) MARYLAND				9a. FACILITY NAME (If not institution, give street and number) 13 S. PAYSON STREET		9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE	
9c. COUNTY OF DEATH N/A				10a. STATE MARYLAND			
10b. COUNTY N/A				10c. CITY, TOWN OR LOCATION BALTIMORE			
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER 13 S. PAYSON STREET			
10f. ZIP CODE 21223				10g. CITIZEN OF WHAT COUNTRY? U.S.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (14 or 5+) 				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) DISABLED		16b. KIND OF BUSINESS/INDUSTRY N/A	
17. FATHER'S NAME (First, Middle, Last) GOLDIE DOBIE				18. MOTHER'S NAME (First, Middle, Maiden Surname) LAURA THOMAS			
19a. INFORMANT'S NAME (Type/Print) GRETA SCOTT				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 622 LOWGROUND RD. EMPORIA, VIRGINIA 23847			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MT. ZION 5-8		20c. LOCATION — City or Town, State BALTIMORE, MARYLAND		21. SIGNATURE OF FUNERAL SERVICE LICENSEE 	
22. NAME AND ADDRESS OF FACILITY IRVIN CARROLL FUNERAL HOME 1712 W. NORTH AVENUE				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → RENAL FAILURE Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DIABETES a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 8 <input type="checkbox"/>		28a. DATE OF INJURY (Month, Day, Year) N/A		28b. TIME OF INJURY N/A		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED N/A		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) N/A		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) N/A		29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D21420		29d. DATE SIGNED (Month, Day, Year) MAY 9 95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) CURTIS E. DAVIS 1500 SECURE HOSP BALTIMORE MD 21223							
31. DATE FILED (Month, Day, Year) MAY 08 1995				REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: Item 23 marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 13922

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) CHARLES AUGUSTUS DeGalleford JR.				2. DATE OF DEATH MONTH APRIL DAY 29 YEAR 1995		3. TIME OF DEATH 9:06 AM	
4. SOCIAL SECURITY NUMBER 220-24-8939		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 64 YRS.		7. DATE OF BIRTH (Month, Day, Year) OCT 21, 1930	
9a. FACILITY NAME (If not Institution, give street and number) 8213 OLD Harford Rd.				9b. CITY, TOWN OR LOCATION OF DEATH PARKVILLE		9c. COUNTY OF DEATH Balto.	
10a. STATE Md.		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Parkville		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 8213 OLD Harford Rd.				10f. ZIP CODE 21234		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1947-1950		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) —		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SCHOOL BUS DRIVER		16b. KIND OF BUSINESS/INDUSTRY Baltimore, County			
17. FATHER'S NAME (First, Middle, Last) CHARLES A. DeGalleford SR				18. MOTHER'S NAME (First, Middle, Maiden Surname) ELIZABETH Kagle			
19a. INFORMANT'S NAME (Type/Print) Nancy L. DeGalleford				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8213 OLD Harford Rd. Balto. Md. 21234			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Dulaney Valley Mem. Gdns 5/2/95		20c. LOCATION — City or Town, State Timonium, Md.		20d. DATE 5/2/95	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Robert W. Jones</i>				22. NAME AND ADDRESS OF FACILITY EVANS CHAPEL of Memories 8800 Harford Rd Balto. Md. 21234			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute myocardial infarction DUE TO (OR AS A CONSEQUENCE OF): ASCVD Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. Also history of Acute myocardial infarction 1976 DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) N/A		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Gerald Maggidi MD</i>				29c. LICENSE NUMBER D06973		29d. DATE SIGNED (Month, Day, Year) 5/1/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 8100 Harford Rd Balto. MD 21234 DR. Gerald Maggidi							
31. DATE FILED (Month, Day, Year) MAY 08 1995				32. REGISTRAR'S SIGNATURE <i>John Andrew Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL HOME: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



(3)



95 13923

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Nicolo DIGIORGIO				2. DATE OF DEATH MONTH May DAY 4 , YEAR 1995		3. TIME OF DEATH YEAR 12:55 P M	
4. SOCIAL SECURITY NUMBER 217-50-8539		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 65 YRS.		7. DATE OF BIRTH (Month, Day, Year) SEPT 15 1929	
8. BIRTHPLACE (State or Foreign Country) ITALY				9a. FACILITY NAME (If not institution, give street and number) FRANKLIN SQUARE HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH ROSEDALE	
9c. COUNTY OF DEATH Baltimore				10a. STATE MARYLAND		10b. COUNTY Baltimore	
10c. CITY, TOWN OR LOCATION PARKVILLE				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 8901 ARONDALE ROAD	
10f. ZIP CODE 21234				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: WHITE				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2 YRS. College (1-4 or 5+) CUSTODIAN			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CUSTODIAN				16b. KIND OF BUSINESS/INDUSTRY BALTIMORE COUNTY BOARD OF EDUCATION			
17. FATHER'S NAME (First, Middle, Last) SALVATORE DiGiorgio				18. MOTHER'S NAME (First, Middle, Maiden Surname) ANGELA CERNIGLIA			
19a. INFORMANT'S NAME (Type/Print) SALVATORE DiGiorgio				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8901 ARONDALE ROAD PARKVILLE, MARYLAND 21234			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) PARKWOOD CEMETERY DATE 5-5			
20c. LOCATION — City or Town, State PARKVILLE, MARYLAND				21. SIGNATURE OF FUNERAL SERVICE LICENSEE 			
22. NAME AND ADDRESS OF FACILITY EVANS CHAPEL OF MEMORIES 8800 HARFORD ROAD - PARKVILLE				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Anaerobic sepsis DUE TO (OR AS A CONSEQUENCE OF): Metastatic prostatic cancer Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. c. d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>			
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY M 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 28d. DESCRIBE HOW INJURY OCCURRED 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER 			
29c. LICENSE NUMBER R D 1757				29d. DATE SIGNED (Month, Day, Year) 5/4/95			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Robert Delatorre 9000 Franklin Square Dr. Baltimore, Maryland 21237							
31. DATE FILED (Month, Day, Year) MAY 08 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



3

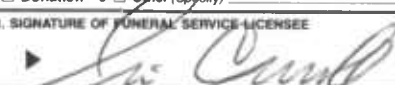
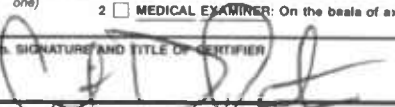
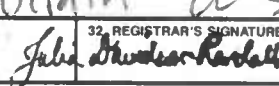
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95 13924

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) HENRY LEE DYAL				2. DATE OF DEATH MONTH 4 DAY 26 YEAR 95		13. TIME OF DEATH 1712 P	
4. SOCIAL SECURITY NUMBER 260-28-2531		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 67 YRS.		7. DATE OF BIRTH (Month, Day, Year) 3 4 1928	
9a. FACILITY NAME (If not institution, give street and number) 601 N. EUTAW STREET				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE		9c. COUNTY OF DEATH N/A	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION BALTIMORE		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 601 N. EUTAW STREET				10f. ZIP CODE 21201		10g. CITIZEN OF WHAT COUNTRY? U.S.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES W.W.II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) 		18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) PRSSER		18b. KIND OF BUSINESS/INDUSTRY DRY CLEANING			
17. FATHER'S NAME (First, Middle, Last) ERNEST ROYAL				18. MOTHER'S NAME (First, Middle, Maiden Surname) DOROTHY DYAL			
19a. INFORMANT'S NAME (Type/Print) RUBY DYAL				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 601 N. EUTAW STREET BALTIMORE MARYLAND			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) BRUNSWICK 5-1		20c. LOCATION — City or Town, State BRUNSWICK, GEORGIA			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY IRVIN CARROLL 1712 W. NORTH AVENUE			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastatic Brain tumor DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death 2 months							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) N/A		28b. TIME OF INJURY N/A		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) N/A		28e. DESCRIBE HOW INJURY OCCURRED N/A			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) N/A					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER P5507		29d. DATE SIGNED (Month, Day, Year) May 4, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Arthur Dilatin 22 S. Greene St Balt. MD 21201							
31. DATE FILED (Month, Day, Year) MAY 08 1995		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE FUNERAL HOME OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13925

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) EDWARD D. DUODERAR				2. DATE OF DEATH MONTH MAY DAY 3 YEAR 1995				3. TIME OF DEATH 1 P.M.	
4. SOCIAL SECURITY NUMBER 220 16 0163		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 69 YRS.		7. DATE OF BIRTH (Month, Day, Year) JULY 31 1925		8. BIRTHPLACE (State or Foreign Country) MARYLAND	
9a. FACILITY NAME (If not institution, give street and number) 3316 SUMMITT AVE.				9b. CITY, TOWN OR LOCATION OF DEATH CARNEY				9c. COUNTY OF DEATH BALTIMORE	
10a. STATE MARYLAND				10b. COUNTY BALTIMORE		10c. CITY, TOWN OR LOCATION CARNEY			
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 3316 SUMMITT AVE.		10f. ZIP CODE 21234		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES W.W.II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 YRS. College (1-4 or 5+) PLANNING ENGINEER				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) ELECTRONIC				16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) Ben DUODERAR				18. MOTHER'S NAME (First, Middle, Maiden Surname) MARY DAMEER					
19a. INFORMANT'S NAME (Type/Print) BERNARDINE E. DUODERAR				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3316 SUMMITT AVE. CARNEY, MARYLAND 21234					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GARRISON FOREST				20c. LOCATION — City or Town, State 5-3 GARRISON, MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE [Signature]				22. NAME AND ADDRESS OF FACILITY EVANSCHAPEL OF MEMORIES 8800 HARFORD ROAD - PARKVILLE					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cancer of esophagus - 6 P.m. Approximate Interval Between Onset and Death hours Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
				28d. DESCRIBE HOW INJURY OCCURRED					
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)					
				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER [Signature]				29c. LICENSE NUMBER D26585		29d. DATE SIGNED (Month, Day, Year) MAY 4, 1995			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. RICHARD M. HIRATA 1001 CROMWELL BRIDGE ROAD Towson									
31. DATE FILED (Month, Day, Year) MAY 08 1995				32. REGISTRAR'S SIGNATURE [Signature]					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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95 13926

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Johnnie L. Davis				2. DATE OF DEATH MONTH 4 DAY 28 YEAR 95		3. TIME OF DEATH 3:27 PM	
4. SOCIAL SECURITY NUMBER 213-07-4240		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 80 YRS.		7. DATE OF BIRTH (Month, Day, Year) NOV. 15, 1914	
8. BIRTHPLACE (State or Foreign Country) SOUTH CAROLINA				9a. FACILITY NAME (If not institution, give street and number) BON SECOURS HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE	
9c. COUNTY OF DEATH N/A				10a. STATE MARYLAND			
10b. COUNTY ANNE ARUNDEL		10c. CITY, TOWN OR LOCATION SEVERN		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 7904 S. CARTIER COURT	
10f. ZIP CODE 21144		10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6TH GRADE College (1-4 or 5+) LABORER		16. KIND OF BUSINESS/INDUSTRY WHOLESALE PRODUCE WAREHOUSE	
17. FATHER'S NAME (First, Middle, Last) GEORGE DAVIS				18. MOTHER'S NAME (First, Middle, Maiden Surname) NANCY WOODARD			
19a. INFORMANT'S NAME (Type/Print) HARRY HARRISON				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7904 S. CARTIER CT. SEVERN, MD. 21144			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MEADOWBRIDGE CEMETERY 54-95		20c. LOCATION — City or Town, State HOWARD CO., MARYLAND		21. SIGNATURE OF FUNERAL SERVICE LICENSEE 	
22. NAME AND ADDRESS OF FACILITY JOSEPH H. BROWN JR FUNERAL HOME, P.A. 1913 W. BALTIMORE ST., BALTIMORE, MD. 21223		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Lung Cancer DUE TO (OR AS A CONSEQUENCE OF): respiratory failure DUE TO (OR AS A CONSEQUENCE OF): Hypertensive Cardiovascular Disease DUE TO (OR AS A CONSEQUENCE OF): Sepsis		Approximate Interval Between Onset and Death		24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER Rosita R. Cruz M.D.	
29c. LICENSE NUMBER D30355		29d. DATE SIGNED (Month, Day, Year) 4/28/95		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ROSITA R. CRUZ M.D. BON SECOURS HOSPITAL		31. DATE FILED (Month, Day, Year) MAY 6 8 1995	
32. REGISTRAR'S SIGNATURE 							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after burial in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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95 13927

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JOHN HENRY EVLER				2. DATE OF DEATH MONTH MAY DAY 5 YEAR 1995		3. TIME OF DEATH 3:30 P.M.	
4. SOCIAL SECURITY NUMBER 217-10-9908		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 84 YRS.		7. DATE OF BIRTH (Month, Day, Year) JAN 31 1911	
9a. FACILITY NAME (If not institution, give street and number) MERIDIAN - HAMILTON				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE		9c. COUNTY OF DEATH N/A	
10a. STATE Md				10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION PARKVILLE	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER 2919 KNOLL ACRE DR				10f. ZIP CODE 21234		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2 YRS. College (1-4 or 5+) ELECTRICIAN				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) ELECTRICIAN		16b. KIND OF BUSINESS/INDUSTRY UTILITY - POTOMAC Edison	
17. FATHER'S NAME (First, Middle, Last) JOHN WILLIAM EVLER				18. MOTHER'S NAME (First, Middle, Maiden Surname) ELIZABETH MAGLENA WISE			
19a. INFORMANT'S NAME (Type/Print) RICHARD A. EVLER				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2919 KNOLL ACRE DRIVE, CARNEY, MARYLAND 21234			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MOUNT OLIVE CEMETERY 5-10		20c. LOCATION — City or Town, State FREDERICK, MARYLAND			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE [Signature]				22. NAME AND ADDRESS OF FACILITY EVANS CHAPEL OF CHIMES 2225 YORK ROAD - Timonium			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ADENOCARCINOMA OF ESOPHAGOGASTRIC JUNCTION WITH LIVER METASTASES Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER [Signature]				29c. LICENSE NUMBER D16619		29d. DATE SIGNED (Month, Day, Year) May 5, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) C. VERGARA - SCARES 2947 ST. PAUL ST. BALT. MD. 21218							
31. DATE FILED (Month, Day, Year) MAY 08 1995		32. REGISTRAR'S SIGNATURE [Signature]					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13928

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) VERONICA THERESA EVERSON				2. DATE OF DEATH MONTH MAY DAY 6 , YEAR 1995		3. TIME OF DEATH 11:12 A.M.	
4. SOCIAL SECURITY NUMBER 110-13-7267		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 69 YRS.		7. DATE OF BIRTH (Month, Day, Year) SEPT. 11, 1925	
9a. FACILITY NAME (If not institution, give street and number) 9234 THROGMORTON ROAD				9b. CITY, TOWN OR LOCATION OF DEATH CARLY		9c. COUNTY OF DEATH BALTIMORE	
10a. STATE MARYLAND				10b. COUNTY BALTIMORE		10c. CITY, TOWN OR LOCATION CARLY	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 9234 THROGMORTON ROAD			
10f. ZIP CODE 21234				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 YRS.		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) LIBRARIAN		16b. KIND OF BUSINESS/INDUSTRY BALTIMORE COUNTY LIBRARY			
17. FATHER'S NAME (First, Middle, Last) FRANCIS MCKEON				18. MOTHER'S NAME (First, Middle, Maiden Surname) JULIA DALY			
19a. INFORMANT'S NAME (Type/Print) JEFFERY R. EVERSON				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9234 THROGMORTON ROAD CARLY, MARYLAND 21234			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GARRISON FOREST		20c. LOCATION — City or Town, State GARRISON, MARYLAND		20d. DATE 5-10	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY EVANS CHAPEL OF MEMORIES 8800 HARFORD ROAD - PARKVILLE			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → cancer of gall bladder DUE TO (OR AS A CONSEQUENCE OF): b. Liver failure DUE TO (OR AS A CONSEQUENCE OF): c. Obstructive Jaundice DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							Approximate interval Between Onset and Death 2 yrs -
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. cholangitis.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							24c. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER D 22105		29d. DATE SIGNED (Month, Day, Year) MAY 8, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. PUKUNO D. DOLKAR MD 2401 W. Belvedere Ave Balto. Md 21215							
31. DATE FILED (Month, Day, Year) MAY 08 1995				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

12

2

95 13929

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) <u>Marie E. Foster</u>				2. DATE OF DEATH MONTH <u>May</u> DAY <u>5</u> YEAR <u>1995</u>		3. TIME OF DEATH <u>7:20 P</u> M	
4. SOCIAL SECURITY NUMBER <u>213-12-3092</u>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>83</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>May 13, 1911</u>	
8. BIRTHPLACE (State or Foreign Country) <u>Maryland</u>				9a. FACILITY NAME (If not institution, give street and number) <u>Northwest Hospital</u>		9b. CITY, TOWN OR LOCATION OF DEATH <u>Baltimore</u>	
9c. COUNTY OF DEATH <u>N/A</u>				10a. STATE <u>Maryland</u>		10b. COUNTY <u>N/A</u>	
10c. CITY, TOWN OR LOCATION <u>Baltimore</u>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. ZIP CODE <u>21201</u>	
10f. STREET AND NUMBER <u>3730 Courtleigh Drive</u>				10g. CITIZEN OF WHAT COUNTRY? <u>USA</u>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. <u>Black</u>				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u>2</u>			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Food Service Manager</u>				16b. KIND OF BUSINESS/INDUSTRY <u>Balto. City</u>			
17. FATHER'S NAME (First, Middle, Last) <u>Charles Taylor</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Nora Newton</u>			
19a. INFORMANT'S NAME (Type/Print) <u>Sara Foster</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>3730 Courtleigh Drive Balto. Md.</u>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium or other place) <u>Arbutus</u> DATE <u>5/10/95</u>			
20c. LOCATION — City or Town, State <u>Balto. Co. Md.</u>				21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Joseph L. Russ</u>			
22. NAME AND ADDRESS OF FACILITY <u>Joseph L. Russ Funeral Home</u> <u>2222 W. North Ave. Balto. Md. 21216</u>				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Sepsis</u> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <u>CHF, Myhfi-infarct Dementia,</u> <u>Chronic Renal Failure, Hypertension, Afib</u> DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>			
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY M <input type="checkbox"/> I <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 28d. DESCRIBE HOW INJURY OCCURRED 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <u>Cezileen M. Burkens</u>			
29c. LICENSE NUMBER <u>836872</u>				29d. DATE SIGNED (Month, Day, Year) <u>May 5, 1995</u>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>Northwest Hosp Center, Randallstown, MD</u>							
31. DATE FILED (Month, Day, Year) <u>MAY 08 1995</u>				32. REGISTRAR'S SIGNATURE <u>John D. ...</u>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13930

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Edythe Gertrude Filbert				2. DATE OF DEATH MONTH May DAY 5 YEAR 1995		3. TIME OF DEATH 1:50 A.	
4. SOCIAL SECURITY NUMBER 215-01-5102		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 92 YRS.		7. DATE OF BIRTH (Month, Day, Year) November 3, 1902	
8. BIRTHPLACE (State or Foreign Country) Virginia				9a. FACILITY NAME (If not Institution, give street and number) Meridian Nursing Center- Hamilton		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore	
9c. COUNTY OF DEATH N/A				10a. STATE Maryland		10b. COUNTY Baltimore	
10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 1801 Forrest Road	
10f. ZIP CODE 21234				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: White				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College (1-4 or 5+)			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Personnel Dept.				16b. KIND OF BUSINESS/INDUSTRY Schleiser Co.			
17. FATHER'S NAME (First, Middle, Last) Reginald Noel Pendelton				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Garthright			
19a. INFORMANT'S NAME (Type/Print) Ellwood N. Filbert				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as 10e			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery or other place) Moreland Mem. Pk. 5/8/95		20c. LOCATION — City or Town, State Baltimore, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSE <i>Donald E. Schuler</i>				22. NAME AND ADDRESS OF FACILITY Leonard J. Ruck Funeral Home, Inc. 5305 Harford Road - Balto Md 21214			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Diabetes Mellitus DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. c. d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Senile Dementia							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE NOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Howard M. Bond</i>				29c. LICENSE NUMBER 019793		29d. DATE SIGNED (Month, Day, Year) 5/15/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Howard Bond M.D. 9618 Belair Road - 21236							
31. DATE FILED (Month, Day, Year) MAY 08 1995				32. REGISTRAR'S SIGNATURE <i>John Andrew Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director. If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13931

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

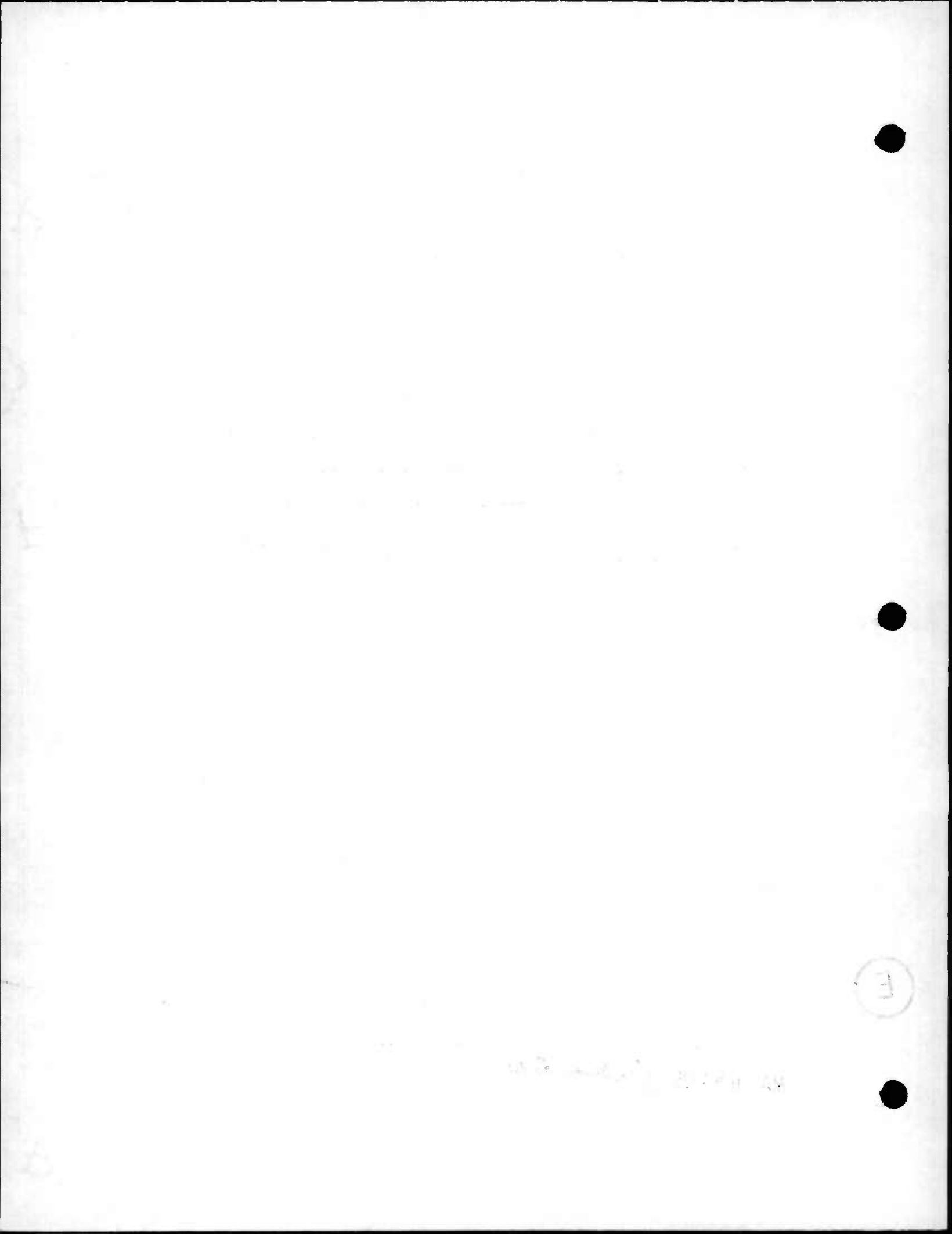
1. DECEASED'S NAME (First, Middle, Last) Grace S. Foster				2. DATE OF DEATH MONTH DAY YEAR May 4, 1995		3. TIME OF DEATH 12:15 P. M.	
4. SOCIAL SECURITY NUMBER 215-82-6015		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 91 YRS.		7. DATE OF BIRTH (Month, Day, Year) 11-30-1903	
9a. FACILITY NAME (If not institution, give street and number) 1033 Marleigh Circle				9b. CITY, TOWN OR LOCATION OF DEATH Towson		9c. COUNTY OF DEATH Baltimore	
RESIDENCE OF DECEASED							
10a. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Timonium		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 15 Evans Ave.				10f. ZIP CODE 21093		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) 10				16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home	
17. FATHER'S NAME (First, Middle, Last) James A. Hutchins				18. MOTHER'S NAME (First, Middle, Maiden Surname) Sarah Sinclair			
19a. INFORMANT'S NAME (Type/Print) Melville T. Foster, Jr.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1033 Marleigh Circle, Towson, Md. 21204			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of institution or place) Towson Funeral Home, Inc. 5-5-95		20c. LOCATION — City or Town, State Towson, Maryland 21204			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Wallace S. Brooks, Jr.				22. NAME AND ADDRESS OF FACILITY Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Md. 21204			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cardiac Arrest CVA Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER Paul Rivas, M.D.		29c. LICENSE NUMBER D25488		29d. DATE SIGNED (Month, Day, Year) 5/4/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Paul Rivas, M.D. 1205 York Road, Lutherville, Maryland 21093							
31. DATE FILED (Month, Day, Year) MAY 08 1995		32. DECEASED'S SIGNATURE					

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director, page 4 should be retained by the medical examiner, or removal.



95 13932

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) John Edward Frank				2. DATE OF DEATH MONTH May DAY 5 YEAR 1995		3. TIME OF DEATH 10:10 A.M.	
4. SOCIAL SECURITY NUMBER 220-42-7172		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 49 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 17, 1945	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) 6013 Snowdens Run Road (Home)		9b. CITY, TOWN OR LOCATION OF DEATH Sykesville	
9c. COUNTY OF DEATH Carroll County				10a. STATE Maryland		10b. COUNTY Carroll County	
10c. CITY, TOWN OR LOCATION Sykesville				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 6013 Snowdens Run Road	
10f. ZIP CODE 21784				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES Army Reserves				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) 4				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Trust Officer		16b. KIND OF BUSINESS/INDUSTRY Banking	
17. FATHER'S NAME (First, Middle, Last) Joseph Frank				18. MOTHER'S NAME (First, Middle, Maiden Surname) Helen Groh			
19a. INFORMANT'S NAME (Type/Print) Mrs. Cheryl A. Frank (Wife)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6013 Snowdens Run Road Sykesville, MD 21784			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Lake View Cemetery 5/8/95		20c. LOCATION — City or Town, State Sykesville, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Brian L. Haight				22. NAME AND ADDRESS OF FACILITY HAIGHT FUNERAL HOME (P.O. Box 195) Sykesville, MD 21784 (410)-795-1400			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. LUNG CANCER							
DUE TO (OR AS A CONSEQUENCE OF):							
b. KIDNEY FAILURE							
DUE TO (OR AS A CONSEQUENCE OF):							
c. HYPERTENSION							
DUE TO (OR AS A CONSEQUENCE OF):							
d.							
Approximate Interval Between Onset and Death 18 months							
Approximate Interval Between Onset and Death 3 months							
Approximate Interval Between Onset and Death 3 months							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Frank D. Howard MD				29c. LICENSE NUMBER 044636		29d. DATE SIGNED (Month, Day, Year) 5/5/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Frank D. Howard 711 W. 40th Street BALTIMORE MD 21211							
31. DATE FILED (Month, Day, Year) MAY 08 1995				32. REGISTRAR'S SIGNATURE John D. Howard			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

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BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760



BALTIMORE, MARYLAND 21215-0020



95 13933

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Sammy Frierson				2. DATE OF DEATH MONTH MAY DAY 1 YEAR 1995				3. TIME OF DEATH 4:50 A.M.					
4. SOCIAL SECURITY NUMBER 219-76-4538				5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 32 YRS.		7. DATE OF BIRTH (Month, Day, Year) OCT. 7, 1962		8. BIRTHPLACE (State or Foreign Country) FLORIDA			
9a. FACILITY NAME (If not institution, give street and number) Johns Hopkins Bayview Med Center						9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE			9c. COUNTY OF DEATH N/A				
RESIDENCE OF DECEDENT													
10a. STATE MARYLAND				10b. COUNTY N/A				10c. CITY, TOWN OR LOCATION BALTIMORE				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 4940 EASTERN AVENUE						10f. ZIP CODE 21224			10g. CITIZEN OF WHAT COUNTRY? USA				
11. MARITAL STATUS SINGLE <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— if yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10TH GRADE College (1-4 or 5+) LABORER				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) LABORER				16b. KIND OF BUSINESS/INDUSTRY A&A OIL SPILL COMPANY					
17. FATHER'S NAME (First, Middle, Last) HAZEL FRIERSON						18. MOTHER'S NAME (First, Middle, Maiden Surname) CLARA JAMES							
19a. INFORMANT'S NAME (Type/Print) CLARA FRIERSON						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4461 ELDONE RD, BALTIMORE, MD. 21229							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MT. ZION CEMETERY 5-5-95				20c. LOCATION — City or Town, State BALTIMORE, MD.					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 						22. NAME AND ADDRESS OF FACILITY JOSEPH H. BROWN JR. FUNERAL HOME 1913 W. BALTIMORE ST., BALTO. MD. 21223							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Retroviral disease DUE TO (OR AS A CONSEQUENCE OF):										Approximate Interval Between Onset and Death 1 year			
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST													
b. DUE TO (OR AS A CONSEQUENCE OF):													
c. DUE TO (OR AS A CONSEQUENCE OF):													
d. DUE TO (OR AS A CONSEQUENCE OF):													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.													
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO													
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO													
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED			
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER D. Brown MD						29c. LICENSE NUMBER N4173448		29d. DATE SIGNED (Month, Day, Year) 5/1/95					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) C. V. Plowe MD Dir of Infectious Diseases Johns Hopkins Hospital Baltimore													
31. DATE FILED (Month, Day, Year) MAY 08 1995				32. REGISTRAR'S SIGNATURE 									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

E

DIVISION OF VITAL RECORDS, P.O. BOX 68760
BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1928 8 10 20

95 13934

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Thomas Howard GARRETT II				2. DATE OF DEATH MONTH May DAY 06 YEAR 1995		3. TIME OF DEATH 11:00 A.M.	
4. SOCIAL SECURITY NUMBER 233-58-4003		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 55 YRS.		7. DATE OF BIRTH (Month, Day, Year) OCT 1, 1939	
8a. FACILITY NAME (If not institution, give street and number) Franklin Square Hospital				8b. CITY, TOWN OR LOCATION OF DEATH Essex		8c. COUNTY OF DEATH Baltimore County	
9. RESIDENCE OF DECEDENT				10c. CITY, TOWN OR LOCATION Joppatowne		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10a. STATE Maryland		10b. COUNTY Harford		10f. ZIP CODE 21085		10g. CITIZEN OF WHAT COUNTRY? USA	
10e. STREET AND NUMBER 421 Barksdale Road		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1956-59		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Special Assistant to the Dir. of Parking Facilities		16b. KIND OF BUSINESS/INDUSTRY University of Maryland At Baltimore		14. RACE — American Indian, Black, White, etc. Specify: White	
17. FATHER'S NAME (First, Middle, Last) Thomas Howard Garrett, Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Gray Howell			
19a. INFORMANT'S NAME (Type/Print) Phyllis A. Garrett				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 421 Barksdale Rd. Joppatowne, MD 21085			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of place, date, time) Metro Crematory, Inc. 05/08/95		20c. LOCATION — City or Town, State Baltimore, MD		21. SIGNATURE OF FUNERAL SERVICE LICENSEE George E. MacNabb	
22. NAME AND ADDRESS OF FACILITY Cremation Society of Maryland 299 Frederick Rd. Baltimore, MD 21228							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. Pneumonia DUE TO (OR AS A CONSEQUENCE OF): b. Probable Aspiration DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death 2 hours 2 hours							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Stacey Dyson MD				29c. LICENSE NUMBER R.D. 1767		29d. DATE SIGNED (Month, Day, Year) 5/6/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Stacey Dyson, MD 9000 Franklin Square Drive Baltimore, MD 21237							
31. DATE FILED (Month, Day, Year) MAY 08 1995				32. REGISTRAR'S SIGNATURE John Davidson Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13935

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) James <u>EVANS</u> GUY, SR.				2. DATE OF DEATH MONTH DAY YEAR May 6, 1995		3. TIME OF DEATH 8:00 P M	
4. SOCIAL SECURITY NUMBER 214-12-2457		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 72 YRS.		7. DATE OF BIRTH (Month, Day, Year) MAY 18 1922	
8. BIRTHPLACE (State or Foreign Country) MARYLAND				9a. FACILITY NAME (If not institution, give street and number) FRANKLIN SQUARE HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH ROSEDALE	
9c. COUNTY OF DEATH Baltimore				10a. STATE MARYLAND		10b. COUNTY BALTIMORE	
10c. CITY, TOWN OR LOCATION PARKVILLE				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 9503 TIABERRY LANE	
10f. ZIP CODE 21234				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES W.W.II				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 YRS.				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) ELECTRONIC		16b. KIND OF BUSINESS/INDUSTRY MARTIN MARIETTA	
17. FATHER'S NAME (First, Middle, Last) HERBERT S. GUY				18. MOTHER'S NAME (First, Middle, Maiden Surname) KATHERINE MARIE HELO			
19a. INFORMANT'S NAME (Type/Print) ELLEN BEN GUY				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9503 TIABERRY LANE PARKVILLE MARYLAND 21234			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MORRIS MEMORIAL PARK 5-3		20c. LOCATION — City or Town, State PARKVILLE MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE [Signature]				22. NAME AND ADDRESS OF FACILITY EVANS CHAPEL OF MEMORIES 3800 HARFORD ROAD - PARKVILLE			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Small cell carcinoma of lung</u> DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death 1 year Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Nimish Gosrani MD				29c. LICENSE NUMBER R D 1775		29d. DATE SIGNED (Month, Day, Year) 5. 6. 95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Nimish Gosrani 9000 Franklin Square Dr. Baltimore, Maryland 21237							
31. DATE FILED (Month, Day, Year) MAY 08 1995 [Signature]							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 23 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13936

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Vickie Jean Hatfield</i>				2. DATE OF DEATH MONTH DAY YEAR <i>April 20, 1995</i>				3. TIME OF DEATH P. M. <i>4 P.</i>					
4. SOCIAL SECURITY NUMBER <i>214-50-2573</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>43</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) <i>Aug. 31, 1951</i>		8. BIRTHPLACE (State or Foreign Country) <i>Maryland</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Washington Adventist Hospital</i>						9b. CITY, TOWN OR LOCATION OF DEATH <i>Takoma Park</i>				9c. COUNTY OF DEATH <i>Montgomery</i>			
RESIDENCE OF DECEDENT													
10a. STATE <i>Maryland</i>		10b. COUNTY <i>Prince George</i>		10c. CITY, TOWN OR LOCATION <i>College Park</i>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
10e. STREET AND NUMBER <i>5217 Iroquois Street</i>				10f. ZIP CODE <i>20740</i>				10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>0</i>				15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Office Manager</i>				15b. KIND OF BUSINESS/INDUSTRY <i>Furniture</i>					
17. FATHER'S NAME (First, Middle, Last) <i>John Dudley</i>						18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Roberta Updike</i>							
19a. INFORMANT'S NAME (Type/Print) <i>H. Thomas Hatfield</i>						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>5217 Iroquois Street, College Park, Maryland 20740</i>							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Maryland Veterans Cemetery 4/24</i>				20c. LOCATION — City or Town, State <i>Crownsville, Maryland</i>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>						22. NAME AND ADDRESS OF FACILITY <i>Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Laurel, MD 20707</i>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>EISEN MENGERS SYNDROME</i>													
Sequitely ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST													
a. DUE TO (OR AS A CONSEQUENCE OF): <i>ATRIAL SEPTAL DEFECT</i>													
b. DUE TO (OR AS A CONSEQUENCE OF):													
c. DUE TO (OR AS A CONSEQUENCE OF):													
d. DUE TO (OR AS A CONSEQUENCE OF):													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.													
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO													
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO													
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Heiter K. Collison M.D.</i>						29c. LICENSE NUMBER <i>02675</i>		29d. DATE SIGNED (Month, Day, Year) <i>5/2/95</i>					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>HEITER K. COLLISON M.D. 8401 COLESVILLE RD 99 MD</i>													
31. DATE FILED (Month, Day, Year) <i>MAY 08 1995</i>				31. REGISTRAR'S SIGNATURE <i>[Signature]</i>									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95-2596-510
B.K.S

ITEMS: 23 PART I, 27, PER MEO FILM G-724 6/5/95 t.t

95 13937

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) SHAWN M. HEAKIN				2. DATE OF DEATH MONTH DAY YEAR MAY 5, 1995		3. TIME OF DEATH 1525 P.M.					
4. SOCIAL SECURITY NUMBER 214-90-7531		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 31 YRS.		7. DATE OF BIRTH (Month, Day, Year) April 15, 1964		8. BIRTHPLACE (State or Foreign Country) MD			
9a. FACILITY NAME (If not institution, give street and number) 835 1/2 WEST LOMBARD STREET				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY			9c. COUNTY OF DEATH n/a				
10a. STATE MD		10b. COUNTY n/a		10c. CITY, TOWN OR LOCATION Baltimore City			10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				
10e. STREET AND NUMBER 835 W. Lombard Street				10f. ZIP CODE 21230		10g. CITIZEN OF WHAT COUNTRY? U.S.A.					
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12th n/a		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Disabled		16b. KIND OF BUSINESS/INDUSTRY n/a							
17. FATHER'S NAME (First, Middle, Last) Oliver Heakin				18. MOTHER'S NAME (First, Middle, Maiden Surname) Charlotte F. Gardner							
19a. INFORMANT'S NAME (Type/Print) Charlotte F. Heakin				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12 W. Fort Avenue, Baltimore, MD 21230							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 8 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Voshell Mem. Gardens, May 8, 1995, Baltimore		20c. LOCATION — City or Town, State							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Victor P. Doda Jr.				22. NAME AND ADDRESS OF FACILITY Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Ave., Baltimore, MD 21230							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → SCHIZOPHRENIA Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER Donald G. Wright MD						29c. LICENSE NUMBER O.C.M.E		29d. DATE SIGNED (Month, Day, Year) MAY 6, 1995			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DONALD G. WRIGHT MD 111 Penn Street, Baltimore, Maryland 21201											
31. DATE FILED (Month, Day, Year) MAY 8 1995		32. REGISTRAR'S SIGNATURE John Andrew Barrett									

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13938

ITEM: 12. PER F.H. FILM G-723 5/8/95 t.t

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) Roger J. Jones Sr.				2. DATE OF DEATH MONTH MAY DAY 2 YEAR 1995		3. TIME OF DEATH 6:22 A.M.	
4. SOCIAL SECURITY NUMBER 193-28-5548		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 55 YRS.		7. DATE OF BIRTH (Month, Day, Year) SEPT. 20, 1939	
9a. FACILITY NAME (If not Institution, give street and number) LAUREL REGIONAL HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH LAUREL		9c. COUNTY OF DEATH PRINCE GEORGE	
RESIDENCE OF DECEASED							
10a. STATE D.C.		10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION WASHINGTON		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 620 7TH STREET, N.E.				10f. ZIP CODE 20002		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES KOREAN		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0				16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) PRINTER		16b. KIND OF BUSINESS/INDUSTRY US GOVERNMENT	
17. FATHER'S NAME (First, Middle, Last) WILLIAM JONES				18. MOTHER'S NAME (First, Middle, Maiden Surname) MARY CAFFREY			
19a. INFORMANT'S NAME (Type/Print) JEANNE JONES				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 620 7TH STREET, NE, WASHINGTON, DC 20002			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) BALTIMORE-WASHINGTON CREMATORY		DATE 5/3		20c. LOCATION — City or Town, State LAUREL, MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>State of Maryland</i>				22. NAME AND ADDRESS OF FACILITY FLECK FUNERAL HOME, INC. 7601 SANDY SPRING ROAD, LAUREL, MARYLAND 20707			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Metastatic Carcinoma of Pancreas IMMEDIATE CAUSE (Final disease or condition resulting in death) → DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying causes given in Part I. Pneumonia, Renal Insufficiency							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DDA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>R. G. Bhojraj MD</i>				29c. LICENSE NUMBER D 23181		29d. DATE SIGNED (Month, Day, Year) 5-2-95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) R. G. BHOJRAJ, MD 704 Gorman Ave T-1 Laurel MD 20707							
31. DATE FILED (Month, Day, Year) MAY 08 1995				32. REGISTRAR'S SIGNATURE <i>John Andrew...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13939

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) EVA C. Jones				2. DATE OF DEATH MONTH May DAY 5 YEAR 95		3. TIME OF DEATH 1:15 PM	
4. SOCIAL SECURITY NUMBER 216-16-8409		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 75 YRS.		7. DATE OF BIRTH (Month, Day, Year) APRIL 18 1920	
9a. FACILITY NAME (If not Institution, give street and number) NORTH ARUNDEL Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Glen Burnie		9c. COUNTY OF DEATH Anne Arundel	
10a. STATE MARYLAND		10b. COUNTY ANNE ARUNDEL		10c. CITY, TOWN OR LOCATION GLEN BURNIE		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 105 HIGHLAND ROAD				10f. ZIP CODE 21060		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER		16b. KIND OF BUSINESS/INDUSTRY HOUSEHOLD			
17. FATHER'S NAME (First, Middle, Last) JOSEPH WITZLER				18. MOTHER'S NAME (First, Middle, Maiden Surname) MARY BUCKHITZE			
19a. INFORMANT'S NAME (Type/Print) ELMER C. JONES SR.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 105 HIGHLAND ROAD GLEN BURNIE, MARYLAND 21060			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MARYLAND VETERANS CEMETERY		20c. LOCATION — City or Town, State 5/9/95 CROWNSVILLE MARYLAND		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Hilary E. Stallings, Jr.				22. NAME AND ADDRESS OF FACILITY STALLINGS FUNERAL HOME P.A. 3111 MOUNTAIN ROAD PASADENA, MARYLAND 21122			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Acute Renal Failure							
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
a. Acute Renal Failure DUE TO (OR AS A CONSEQUENCE OF):							
b. Septicemia DUE TO (OR AS A CONSEQUENCE OF):							
c. Pneumonia DUE TO (OR AS A CONSEQUENCE OF):							
d. Chronic obstructive Pulmonary Disease DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Acute Gastrointestinal bleeding Cerebral Vessels							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER [Signature]				29c. LICENSE NUMBER D45249		29d. DATE SIGNED (Month, Day, Year) 5/5/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SUSHEEL K SHARMA 1600 CRAIN Highway SW - Maryland Glen Burnie							
31. DATE FILED (Month, Day, Year) MAY 9 8 1995							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

3

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Handwritten text at the bottom of the page, possibly a signature or date.

95 13940

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) EDNA E. KERSHAW				2. DATE OF DEATH MONTH MAY DAY 07 YEAR 95		3. TIME OF DEATH 18:50P M	
4. SOCIAL SECURITY NUMBER 218-09-6988		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 90 YRS.	7. DATE OF BIRTH (Month, Day, Year) OCT 22, 1904		8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not institution, give street and number) St. Agnes Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City		9c. COUNTY OF DEATH N/A	
10a. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Lansdowne		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 38 Second Avenue				10f. ZIP CODE 21227		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 3 College (1-4 or 5+) 		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Machine Operator		16b. KIND OF BUSINESS/INDUSTRY Christmas Manufacturer / Ornaments			
17. FATHER'S NAME (First, Middle, Last) Harry T. Smith				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ida Mae Kaiser			
19a. INFORMANT'S NAME (Type/Print) Richard T. Weinknecht				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2580 Sand Hill Rd. Ellicott City, MD 21042			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Lake View Memorial Park 5/11/95		20c. LOCATION — City or Town, State Eldersburg, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE George E. MacNabb				22. NAME AND ADDRESS OF FACILITY MacNabb Funeral Home, P.A. 301 Frederick Rd. Balto., MD 21228			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Pneumonia Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST COVD Arterioductic heart disease							Approximate interval Between Onset and Death 1 wk 4 wks 1 yr
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER John D. ...				29c. LICENSE NUMBER D44701		29d. DATE SIGNED (Month, Day, Year) MAY 07, 95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) THE JOHNS HOPKINS HOSPITAL PAIRACH PINTAVORN 720 KUTLAND AVE BALTIMORE MD. 21205							
31. DATE FILED (Month, Day, Year) MAY 08 1995				32. REGISTRAR'S SIGNATURE John Davidson Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is checked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



3



ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-724 6/5/95 t.t

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ERIC		2. DATE OF DEATH MONTH DAY YEAR MAY 04 95		3. TIME OF DEATH 6:13 P.M.	
4. SOCIAL SECURITY NUMBER 214-82-4415		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 35 YRS.	
7. DATE OF BIRTH (Month, Day, Year) Aug. 8, 1959		8. BIRTHPLACE (State or Foreign Country) Maryland			
9a. FACILITY NAME (If not institution, give street and number) SINAI HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY		9c. COUNTY OF DEATH N/A	
10a. STATE Maryland		10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION Baltimore	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 827 N. Arlington Ave.		10f. ZIP CODE 21217	
10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Contractor		16b. KIND OF BUSINESS/INDUSTRY Moving Company	
17. FATHER'S NAME (First, Middle, Last) Kirkpatrick Lyles		18. MOTHER'S NAME (First, Middle, Maiden Surname) Cantress Kelly			
19a. INFORMANT'S NAME (Type/Print) Kathleen Parker		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3701 Ferndale Ave. Balto, Md. 21207			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of center, cemetery, or other place) Western Star 5/10/95		20c. LOCATION — City or Town, State Balto. Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Joseph L. Russ		22. NAME AND ADDRESS OF FACILITY Joseph L. Russ Funeral Home 2222 W. North Ave. Balto, Md. 21216			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated event resulting in death) LAST a. ACUTE ETHANOL, COCAINE AND NARCOTIC INTOXICATION DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.		Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Pending Investigation 3 <input type="checkbox"/> Accident 4 <input type="checkbox"/> Suicide 5 <input checked="" type="checkbox"/> Homicide 6 <input checked="" type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) FOUND 5-4-95		28b. TIME OF INJURY 5:42 P.M.	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED UNKNOWN			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) FOUND IN HOUSE		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 2914 RIDGEWOOD AVE. BALTIMORE, MARYLAND			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER Dennis J. Chute		29c. LICENSE NUMBER O.C.M.E.	
29d. DATE SIGNED (Month, Day, Year) MAY 5, 1995		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201			
31. DATE FILED (Month, Day, Year) MAY 08 1995		32. REGISTRAR'S SIGNATURE [Signature]			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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95 13942

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JOHN DEE KISNICK SR.				2. DATE OF DEATH MONTH DAY YEAR May 4 1995		3. TIME OF DEATH 7:20 pm	
4. SOCIAL SECURITY NUMBER 215-03-1439		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 78 YRS.		7. DATE OF BIRTH (Month, Day, Year) August 4, 1916	
8. BIRTHPLACE (State or Foreign Country) Oklaoma				9a. FACILITY NAME (If not institution, give street and number) Saint Joseph Medical Center		9b. CITY, TOWN OR LOCATION OF DEATH Towson, Maryland	
9c. COUNTY OF DEATH Baltimore				10a. STATE Maryland		10b. COUNTY N/A	
10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 4801 Walther Avenue	
10f. ZIP CODE 21214				10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Chief Clerk		16b. KIND OF BUSINESS/INDUSTRY Maritime/Longshoreman			
17. FATHER'S NAME (First, Middle, Last) William Kisnick				18. MOTHER'S NAME (First, Middle, Maiden Surname) Dicie Connelly			
19a. INFORMANT'S NAME (Type/Print) Mrs. Dorothy Kisnick				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4801 Walther Avenue Baltimore, Md. 21214			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Parkwood Cemetery		DATE 5/8/95		20c. LOCATION — City or Town, State Baltimore, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Mark T. Zavoyna				22. NAME AND ADDRESS OF FACILITY Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Md. 21214			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → CHRONIC RENAL FAILURE							
DUE TO (OR AS A CONSEQUENCE OF):							
SEPSIS							
DUE TO (OR AS A CONSEQUENCE OF):							
CARCINOMA OF THE BLADDER							
DUE TO (OR AS A CONSEQUENCE OF):							
INSULIN DEPENDENT DIABETES MELLITUS							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ANEMIA SECONDARY TO A							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Ceballos, MD				29c. LICENSE NUMBER D25988		29d. DATE SIGNED (Month, Day, Year) 5.4.95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type, Print) DR. CEBALLOS M.D. ST JOSEPH MEDICAL CENTER, TOWSON MARYLAND 21204							
31. DATE FILED (Month, Day, Year) MAY 08 1995				32. REGISTRAR'S SIGNATURE <i>John...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Agilent 1100 Series HPLC system

28412 28413 28414 28415 28416 28417 28418 28419 28420 28421 28422 28423 28424 28425 28426 28427 28428 28429 28430 28431 28432 28433 28434 28435 28436 28437 28438 28439 28440 28441 28442 28443 28444 28445 28446 28447 28448 28449 28450 28451 28452 28453 28454 28455 28456 28457 28458 28459 28460 28461 28462 28463 28464 28465 28466 28467 28468 28469 28470 28471 28472 28473 28474 28475 28476 28477 28478 28479 28480 28481 28482 28483 28484 28485 28486 28487 28488 28489 28490 28491 28492 28493 28494 28495 28496 28497 28498 28499 28500 28501 28502 28503 28504 28505 28506 28507 28508 28509 28510 28511 28512 28513 28514 28515 28516 28517 28518 28519 28520 28521 28522 28523 28524 28525 28526 28527 28528 28529 28530 28531 28532 28533 28534 28535 28536 28537 28538 28539 28540 28541 28542 28543 28544 28545 28546 28547 28548 28549 28550 28551 28552 28553 28554 28555 28556 28557 28558 28559 28560 28561 28562 28563 28564 28565 28566 28567 28568 28569 28570 28571 28572 28573 28574 28575 28576 28577 28578 28579 28580 28581 28582 28583 28584 28585 28586 28587 28588 28589 28590 28591 28592 28593 28594 28595 28596 28597 28598 28599 28600 28601 28602 28603 28604 28605 28606 28607 28608 28609 28610 28611 28612 28613 28614 28615 28616 28617 28618 28619 28620 28621 28622 28623 28624 28625 28626 28627 28628 28629 28630 28631 28632 28633 28634 28635 28636 28637 28638 28639 28640 28641 28642 28643 28644 28645 28646 28647 28648 28649 28650 28651 28652 28653 28654 28655 28656 28657 28658 28659 28660 28661 28662 28663 28664 28665 28666 28667 28668 28669 28670 28671 28672 28673 28674 28675 28676 28677 28678 28679 28680 28681 28682 28683 28684 28685 28686 28687 28688 28689 28690 28691 28692 28693 28694 28695 28696 28697 28698 28699 28700 28701 28702 28703 28704 28705 28706 28707 28708 28709 28710 28711 28712 28713 28714 28715 28716 28717 28718 28719 28720 28721 28722 28723 28724 28725 28726 28727 28728 28729 28730 28731 28732 28733 28734 28735 28736 28737 28738 28739 28740 28741 28742 28743 28744 28745 28746 28747 28748 28749 28750 28751 28752 28753 28754 28755 28756 28757 28758 28759 28760 28761 28762 28763 28764 28765 28766 28767 28768 28769 28770 28771 28772 28773 28774 28775 28776 28777 28778 28779 28780 28781 28782 28783 28784 28785 28786 28787 28788 28789 28790 28791 28792 28793 28794 28795 28796 28797 28798 28799 28800 28801 28802 28803 28804 28805 28806 28807 28808 28809 28810 28811 28812 28813 28814 28815 28816 28817 28818 28819 28820 28821 28822 28823 28824 28825 28826 28827 28828 28829 28830 28831 28832 28833 28834 28835 28836 28837 28838 28839 28840 28841 28842 28843 28844 28845 28846 28847 28848 28849 28850 28851 28852 28853 28854 28855 28856 28857 28858 28859 28860 28861 28862 28863 28864 28865 28866 28867 28868 28869 28870 28871 28872 28873 28874 28875 28876 28877 28878 28879 28880 28881 28882 28883 28884 28885 28886 28887 28888 28889 28890 28891 28892 28893 28894 28895 28896 28897 28898 28899 28900 28901 28902 28903 28904 28905 28906 28907 28908 28909 28910 28911 28912 28913 28914 28915 28916 28917 28918 28919 28920 28921 28922 28923 28924 28925 28926 28927 28928 28929 28930 28931 28932 28933 28934 28935 28936 28937 28938 28939 28940 28941 28942 28943 28944 28945 28946 28947 28948 28949 28950 28951 28952 28953 28954 28955 28956 28957 28958 28959 28960 28961 28962 28963 28964 28965 28966 28967 28968 28969 28970 28971 28972 28973 28974 28975 28976 28977 28978 28979 28980 28981 28982 28983 28984 28985 28986 28987 28988 28989 28990 28991 28992 28993 28994 28995 28996 28997 28998 28999 29000 29001 29002 29003 29004 29005 29006 29007 29008 29009 29010 29011 29012 29013 29014 29015 29016 29017 29018 29019 29020 29021 29022 29023 29024 29025 29026 29027 29028 29029 29030 29031 29032 29033 29034 29035 29036 29037 29038 29039 29040 29041 29042 29043 29044 29045 29046 29047 29048 29049 29050 29051 29052 29053 29054 29055 29056 29057 29058 29059 29060 29061 29062 29063 29064 29065 29066 29067 29068 29069 29070 29071 29072 29073 29074 29075 29076 29077 29078 29079 29080 29081 29082 29083 29084 29085 29086 29087 29088 29089 29090 29091 29092 29093 2909

256 JOURNAL OF DOCUMENTATION

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A CT YRACY DOER AMENYA

2007-08-20

DR. JOSEPH P. MEDICAL CENTER, ST. JOSEPH, MO. 64501-2018

[Faint, illegible handwritten text]

95 13943

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Orsaki Kimon Koumarianos				2. DATE OF DEATH MONTH DAY YEAR May 6, 1995		3. TIME OF DEATH 7:45 P M	
4. SOCIAL SECURITY NUMBER 212-30-8440		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 85 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) March 14, 1910	
9a. FACILITY NAME (If not institution, give street and number) Franklin Square Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Rossville		9c. COUNTY OF DEATH Baltimore	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Rosedale		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 5726 Emelia Avenue				10f. ZIP CODE 21206		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY N/A			
17. FATHER'S NAME (First, Middle, Last) Nicholas Katsotis				18. MOTHER'S NAME (First, Middle, Maiden Surname) Theano Pandazis			
19a. INFORMANT'S NAME (Type/Print) Mr. Kimon M. Koumarianos				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5726 Emelia Avenue Baltimore, Maryland 21206			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Greek Orthodox Cemetery 5/9/95		20c. LOCATION — City or Town, State Baltimore, Maryland		20d. DATE 5/9/95	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Mark T. Zavoyna				22. NAME AND ADDRESS OF FACILITY Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Maryland 21214			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Ischemic bowel DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death 3days
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Congestive heart failure							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURRED			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Nimish Gosrani MD				29c. LICENSE NUMBER R D 1775		29d. DATE SIGNED (Month, Day, Year) 5. 6. 95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Nimish Gosrani 9000 Franklin Square Dr. Baltimore, Maryland 21237							
31. DATE FILED (Month, Day, Year) MAY 08 1995		32. REGISTRAR'S SIGNATURE John A. Howard					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



RECEIVED - 1955 10 14

95 13944

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JOHN V. KRAFT				2. DATE OF DEATH MAY 04 1995		3. TIME OF DEATH 9:02 P.M.					
4. SOCIAL SECURITY NUMBER 217-40-3702		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 51 YRS.		7. DATE OF BIRTH (Month, Day, Year) 03 29 44		8. BIRTHPLACE (State or Foreign Country) MARYLAND			
9a. FACILITY NAME (If not institution, give street and number) ST. AGNES HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY			9c. COUNTY OF DEATH N/A				
10a. STATE MARYLAND		10b. COUNTY BALTIMORE		10c. CITY, TOWN OR LOCATION CATONSVILLE			10d. INSIDE CITY LIMITS 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				
10e. STREET AND NUMBER 6302 FREDERICK ROAD				10f. ZIP CODE 21228		10g. CITIZEN OF WHAT COUNTRY? U.S.A.					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES VIETNAM		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: WHITE				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		College (1-4 or 5+) 0		18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) FIRE-FIGHTER			18b. KIND OF BUSINESS/INDUSTRY PUBLIC SAFETY				
17. FATHER'S NAME (First, Middle, Last) VICTOR C. KRAFT SR.				18. MOTHER'S NAME (First, Middle, Maiden Surname) ALMA D. DIXON							
19a. INFORMANT'S NAME (Type/Print) CHERYL A. KRAFT				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 416 HAZLETT AVENUE-BALTIMORE, MD. 21229							
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify):		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) METRO CREMATORY, INC. 5/9		20c. LOCATION — City or Town, State CATONSVILLE, MD.							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Darryl L. Kaufman</i>				22. NAME AND ADDRESS OF FACILITY RAYMOND C. FINK FUNERAL HOME 21061 426 CRAIN HWY. S.W. GLEN BURNIE, MD.							
23. PART I. Enter the disease, shock, or heart failure complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → s. <i>Head Injuries</i> DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <i>Found 5-4-95</i>		28b. TIME OF INJURY <i>Found 2030 M</i>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED <i>subject fell down steps</i>			
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <i>Home</i>				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <i>6302 Frederick Rd Catonsville, Md</i>					
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dennis J. Chute M.D.</i>						29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) MAY 5, 1995			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dennis J. Chute M.D. 111 Penn Street, Baltimore, Maryland 21201											
31. DATE FILED (Month, Day, Year) MAY 08 1995				32. REGISTRAR'S SIGNATURE <i>John A. Huchler-Karall</i>							

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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3

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JOHN E. KAYLOR				2. DATE OF DEATH MONTH May DAY 4 YEAR 1995		3. TIME OF DEATH 9:50P.M.	
4. SOCIAL SECURITY NUMBER 216 14 1781		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 72 YRS.		7. DATE OF BIRTH (Month, Day, Year) 7/20/22	
9a. FACILITY NAME (If not institution, give street and number) Howard County General Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Columbia		9c. COUNTY OF DEATH Howard	
10a. STATE Md.				10b. COUNTY Carroll		10c. CITY, TOWN OR LOCATION Finki Finksburg	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 4027 Sykesville Rd.			
10f. ZIP CODE 21048				10g. CITIZEN OF WHAT COUNTRY? U.S. A.			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) High School College (1-4 or 5+) =				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Program Analyst		16b. KIND OF BUSINESS/INDUSTRY Security Admin.	
17. FATHER'S NAME (First, Middle, Last) John Nee				18. MOTHER'S NAME (First, Middle, Maiden Surname) Rose Kaylor			
19a. INFORMANT'S NAME (Type/Print) Adrienne Kaylor				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4027 Sykesville Rd. Finksburg, Md.			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Garrison Forest Vet. Cemetery 5/8/95 Garrison, Md.		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Harry W. Haight				22. NAME AND ADDRESS OF FACILITY Haight Funeral Home P.O. Box 194 Sykesville, Md. 21784			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Respiratory failure DUE TO (OR AS A CONSEQUENCE OF): b. Pneumonia DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death weeks weeks							
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Pulmonary embolism right deep venous thrombosis morbid obesity sepsis DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) N/A		28b. TIME OF INJURY N/A		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) N/A		28d. DESCRIBE HOW INJURY OCCURRED N/A		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) N/A	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER [Signature] MD				29c. LICENSE NUMBER D36845		29d. DATE SIGNED (Month, Day, Year) May 5, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MAI-CHI NGUYEN, MD 11055 LITTLE PATUXENT PKWY #107, COLUMBIA, MD 21044							
31. DATE FILED (Month, Day, Year) MAY 08 1995				32. REGISTRAR'S SIGNATURE [Signature]			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 13946

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) SUSAN MARIE LEFTWICH				2. DATE OF DEATH MONTH DAY YEAR APRIL 29, 1995		3. TIME OF DEATH 2:30 AM	
4. SOCIAL SECURITY NUMBER 207 60 4707		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 42 YRS.		7. DATE OF BIRTH (Month, Day, Year) FEB 28, 1953	
8a. FACILITY NAME (If not institution, give street and number) Union Memorial Hospital				8b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE		8c. COUNTY OF DEATH MARYLAND	
9. RESIDENCE OF DECEDENT				10. CITY, TOWN OR LOCATION			
10a. STATE MARYLAND		10b. COUNTY		10c. CITY, TOWN OR LOCATION BALTIMORE		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 405 VENICE AVE.				10f. ZIP CODE 21215		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — if yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 YRS. College (1-4 or 5+) 12 YRS.		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) WAITRESS		16b. KIND OF BUSINESS/INDUSTRY RESTAURANT			
17. FATHER'S NAME (First, Middle, Last) EUGENE PARSONS MILLER				18. MOTHER'S NAME (First, Middle, Maiden Surname) BETTY FAMOUS			
19a. INFORMANT'S NAME (Type/Print) SANDRA G. HARE				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 29 EAST RIDGELY ROAD TIMONUM, MARYLAND 21093			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) OLIVAN VALLEY MEMORIAL 5-2		20c. LOCATION — City or Town, State Timonium, Maryland		20d. DATE 5-2	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE [Signature]				22. NAME AND ADDRESS OF FACILITY EVANS CHAPEL OF CHURCH 2325 YORK ROAD - TIMONUM			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cervical Cancer DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Homicide					
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Frank M. Ables M.D.				29c. LICENSE NUMBER D38972		29d. DATE SIGNED (Month, Day, Year) MAY 1, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) FOUAD M. ABBAS, M.D. UMMS-22 S. GREENE 21201							
31. DATE FILED (Month, Day, Year) MAY 08 1995				32. REGISTRAR'S SIGNATURE [Signature]			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13947

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Gail Patricia Litfin				2. DATE OF DEATH MONTH DAY YEAR MAY 06 1995		3. TIME OF DEATH 1:47 P M	
4. SOCIAL SECURITY NUMBER 213-72-1865		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 37 YRS.	7. DATE OF BIRTH (Month, Day, Year) DEC 07, 1957		8. BIRTHPLACE (State or Foreign Country) Pennsylvania	
9a. FACILITY NAME (If not institution, give street and number) 3537 Greenmount Avenue				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH N/A	
10a. STATE Maryland				10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION Baltimore	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 3537 Greemount Avenue		10f. ZIP CODE 21218	
10g. CITIZEN OF WHAT COUNTRY? USA				11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 5 + College (1-4 or 5+) 5 +	
16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Claims Adjudicator				17. KIND OF BUSINESS/INDUSTRY Equal Opportunity Employment Commission		18. FATHER'S NAME (First, Middle, Last) Jerry S. Litfin	
19. MOTHER'S NAME (First, Middle, Maiden Surname) Kathleen A. Wilkinson				20. INFORMANT'S NAME (Type/Print) Kathleen A. Wilkinson		21. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7208 Chamberlain Rd. Woodlawn, MD 21244	
22. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				23. PLACE AND DATE OF DISPOSITION (Name of facility, street and number, city or town, state, zip code) Metro Crematory, Inc. 05/10/95		24. LOCATION — City or Town, State Baltimore, MD	
25. SIGNATURE OF FUNERAL SERVICE LICENSEE George E. MacNabb				26. NAME AND ADDRESS OF FACILITY MacNabb Funeral Home, P.A. 301 Frederick Rd. Baltimore, MD 21228		27. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → ARRHYTHMIA Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): CARDIOVASCULAR ATHEROSCLEROSIS b. DUE TO (OR AS A CONSEQUENCE OF): HYPERTENSION c. DUE TO (OR AS A CONSEQUENCE OF): END STAGE RENAL DISEASE d. DIABETES MELLITUS	
28. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETES MELLITUS				29. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		30. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
31. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>				32. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		33. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
34. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				35. DATE OF INJURY (Month, Day, Year) MAY 06 1995		36. TIME OF INJURY M	
37. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				38. DESCRIBE HOW INJURY OCCURRED		39. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
40. LOCATION (Street and Number or Rural Route Number, City or Town, State)				41. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		42. SIGNATURE AND TITLE OF CERTIFIER Luis F. Gimenez	
43. LICENSE NUMBER D31960				44. DATE SIGNED (Month, Day, Year) May 08, 1995		45. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Luis Gimenez, M.D. 5601 Loch Raven Blvd. Baltimore, Maryland 21239	
46. DATE FILED (Month, Day, Year) MAY 08 1995				47. REGISTRAR'S SIGNATURE Julia Davidson-Randall		48. TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION	

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 23 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13948

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Margaret J. Legge				2. DATE OF DEATH MONTH May DAY 03 YEAR 1995		3. TIME OF DEATH 4:40 A. M	
4. SOCIAL SECURITY NUMBER 016 22 3803		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 96 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 19, 1898	
8. BIRTHPLACE (State or Foreign Country) Scotland		9a. FACILITY NAME (If not institution, give street and number) Knollwood Manor Nursing Home		9b. CITY, TOWN OR LOCATION OF DEATH Millersville		9c. COUNTY OF DEATH Anne Arundel	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Anne Arundel		10c. CITY, TOWN OR LOCATION Millersville		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 899 Cecil Avenue				10f. ZIP CODE 21108		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 8th College (1-4 or 5+) College (1-4 or 5+)		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Home Maker		15b. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) Robert Grigor				18. MOTHER'S NAME (First, Middle, Maiden Surname) Jobina Cameron			
19a. INFORMANT'S NAME (Type/Print) Donald C. Legge				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1131 Severnview Drive Crownsville, Maryland 21032			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Cedar Grove Cemetery		DATE 5/6		20c. LOCATION — City or Town, State Boston, Massachusetts	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Donna M. Znamierowski</i>				22. NAME AND ADDRESS OF FACILITY George J. Gonce Funeral Home P.A. 4001 Ritchie Hwy. Baltimore, Md. 21225			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → SEPSIS DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MALNUTRITION							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Attending</i>				29c. LICENSE NUMBER D 21776		29d. DATE SIGNED (Month, Day, Year) 5/3/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SURYA MURDA No 203 E PATRASCIO AV BALTIMORE MD 21225							
31. DATE FILED (Month, Day, Year) MAY 08 1995		32. REGISTRAR'S SIGNATURE <i>John Andrew Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13949

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) BONNIE JEAN LEWIS				2. DATE OF DEATH MONTH 5 DAY 5 YEAR 95		3. TIME OF DEATH 6:00 A	
4. SOCIAL SECURITY NUMBER 232-54-2957		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 59 YRS.		7. DATE OF BIRTH (Month, Day, Year) DEC. 23, 1935	
8. BIRTHPLACE (State or Foreign Country) W. VIRGINIA				9a. FACILITY NAME (If not institution, give street and number) 330 STEMMERS RUN ROAD		9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE (ESSEX)	
9c. COUNTY OF DEATH BALTIMORE				10a. STATE MARYLAND		10b. COUNTY BALTIMORE	
10c. CITY, TOWN OR LOCATION ESSEX				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 330 STEMMERS RUN ROAD	
10f. ZIP CODE 21221				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10TH GRADE College (1-4 or 5+) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) ASSEMBLY WORKER		16b. KIND OF BUSINESS/INDUSTRY ARCO METALS			
17. FATHER'S NAME (First, Middle, Last) WILLIAM E. KEEFOVER				18. MOTHER'S NAME (First, Middle, Maiden Surname) LEONA BEATRICE GILLESPIE			
19a. INFORMANT'S NAME (Type/Print) MR. DENNIS W. DENNIS				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1016 PINE HEIGHTS AVENUE - BALTIMORE, MD 21229			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) BEVERLY HILLS MEM. GARDENS 5/8		DATE		20c. LOCATION — City or Town, State WESTOVER, W.VA.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Jackie H. Shannon</i>				22. NAME AND ADDRESS OF FACILITY HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVENUE - BALTIMORE, MD 21229			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → END STAGE ISCHEMIC CARDIOMYOPATHY AND 5 YRS DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST 1. MALIGNANT ARRHYTHMIAS 1 YR. 2. SEVERE TRIPLE VESSEL CORONARY DISEASE 5 YRS DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PREVIOUS MYOCARDIAL INFARCTIONS. VERY POOR LEFT VENTRICULAR FUNCTION; DIABETES TYPE 2 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. Norberto M. Machiran</i> ATTENDING PHYSICIAN				29c. LICENSE NUMBER D16200		29d. DATE SIGNED (Month, Day, Year) 5-5-95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. NORBERTO M. MACHIRAN - 720 MAIDEN CHOICE LANE - CATONSVILLE, MD 21228							
31. DATE FILED (Month, Day, Year) MAY 08 1995							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1997 30 424

95 13950

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JOAN M LOFFT				2. DATE OF DEATH MONTH MAY DAY FIFTH YEAR 1995		3. TIME OF DEATH SEVEN P.M.	
4. SOCIAL SECURITY NUMBER 129-32-3371		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 55 YRS.		7. DATE OF BIRTH (Month, Day, Year) April 15 1940	
9a. FACILITY NAME (If not institution, give street and number) Howard County General Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Columbia		9c. COUNTY OF DEATH Howard	
10a. STATE Maryland		10b. COUNTY Howard		10c. CITY, TOWN OR LOCATION Ellicott City		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 3106 N. Chatham Road				10f. ZIP CODE 21042		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2+		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Diet Technician		16b. KIND OF BUSINESS/INDUSTRY Howard County General Hospital			
17. FATHER'S NAME (First, Middle, Last) Harry Francis Heckmann				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mildred Barbara Meidenbauer			
19a. INFORMANT'S NAME (Type/Print) Patrick M. Lofft				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3106 N. Chatham Rd. Ellicott City, Md. 21042			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Balt-Wash Crematory Inc 5-7-95		DATE Laurel, Md.		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Robert Smith M00544				22. NAME AND ADDRESS OF FACILITY Slack Funeral Home, P.A. Ellicott City, Md. 21043			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. OVARIA CANCER METASTATIC DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death THREE MONTHS
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24e. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO N/A
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Dr. Knigge M.D.				29c. LICENSE NUMBER D 41139		29d. DATE SIGNED (Month, Day, Year) MAY, SEVEN, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 11065 Little Patuxent Parkway, Columbia, M.D.							
31. DATE FILED (Month, Day, Year) MAY 08 1995 <i>John Smith</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR STATE DING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13951

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Marc SHERMAN McFadden				2. DATE OF DEATH MONTH May DAY 2 YEAR 95		3. TIME OF DEATH 11 P M	
4. SOCIAL SECURITY NUMBER 212-78-5594		5. SEX 1 <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 35 YRS.		7. DATE OF BIRTH (Month, Day, Year) Oct. 25, 1959	
9a. FACILITY NAME (If not institution, give street and number) JOSEPH RICHIE HOUSE				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE		9c. COUNTY OF DEATH N/A	
10a. STATE MD				10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION BALTIMORE	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER 529 E. Coldspring Lane			
10f. ZIP CODE 21212				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (13-16) N/A				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Longshoreman		16b. KIND OF BUSINESS/INDUSTRY Waterfront	
17. FATHER'S NAME (First, Middle, Last) GARRIS McFadden				18. MOTHER'S NAME (First, Middle, Maiden Surname) Barbara Sheppard			
19a. INFORMANT'S NAME (Type/Print) Barbara McFadden				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 529 E. Coldspring Lane Balto MD 21212			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Arbutus Men Park 5/5/95		20c. LOCATION — City or Town, State Arbutus, Md		20d. DATE 5/5/95	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Glynis B. Scott				22. NAME AND ADDRESS OF FACILITY March Funeral Home-West 21215 4300 Wabash Ave. Balto. Md			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST						Approximate Interval Between Onset and Death	
a. DUE TO (OR AS A CONSEQUENCE OF): Respiratory Arrest						minutes	
b. DUE TO (OR AS A CONSEQUENCE OF): Dementia						2 mos	
c. DUE TO (OR AS A CONSEQUENCE OF): Acquired Immune Deficiency Syndrome						15 mos	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) HOSPICE					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Robert C. Irwin MD				29c. LICENSE NUMBER 208900		29d. DATE SIGNED (Month, Day, Year) 5-3-95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Robert C. Irwin MD 828 N. Gataway St. Balto. Md 21201							
31. DATE FILED (Month, Day, Year) MAY 08 1995				32. REGISTRAR'S SIGNATURE John A. Sullivan			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13952

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) KATHLEEN M. McFARLAND				2. DATE OF DEATH MONTH DAY YEAR APRIL 27 1995		3. TIME OF DEATH 6:40 P.M.	
4. SOCIAL SECURITY NUMBER 212-28-5125		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 85 YRS.		7. DATE OF BIRTH (Month, Day, Year) JAN 28, 1910	
9a. FACILITY NAME (If not institution, give street and number) DULANEY-TOWSON NURSING HOME				9b. CITY, TOWN OR LOCATION OF DEATH TOWSON		9c. COUNTY OF DEATH BALTIMORE	
10a. STATE MARYLAND		10b. COUNTY		10c. CITY, TOWN OR LOCATION BALTIMORE		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 311 Winston Ave.				10f. ZIP CODE 21212		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 YRS. College (1-4 or 5+) College		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SALES CLERK		15b. KIND OF BUSINESS/INDUSTRY DEPARTMENT STORE			
17. FATHER'S NAME (First, Middle, Last) JAMES McFARLAND				18. MOTHER'S NAME (First, Middle, Maiden Surname) MARY McGE			
19a. INFORMANT'S NAME (Type/Print) FRANCIS G. McFARLAND				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 105 GOTHARD ROAD LUTHERVILLE, MARYLAND 21093			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) NEW LATHROPAL		20c. LOCATION — City or Town, State BALTIMORE, MARYLAND		20d. DATE 5-3	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE [Signature]				22. NAME AND ADDRESS OF FACILITY EVANS CHAPEL OF CHIMES 2325 YORK ROAD - TIMONUM			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Arteriosclerotic Cardio Renal Vascular Dis. IMMEDIATE CAUSE (Final disease or condition resulting in death) → DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER [Signature]				29c. LICENSE NUMBER D-09383		29d. DATE SIGNED (Month, Day, Year) APRIL 28, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR CHARLES F. O'DONNELL 7505 OSLER DRIVE - TOWSON							
31. DATE FILED (Month, Day, Year) MAY 08 1995							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 23 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. The first part of the report deals with the general situation of the country and the progress of the work during the year. It is a summary of the work done and the results obtained. It is a general statement of the work done and the results obtained.

2. The second part of the report deals with the work done during the year. It is a detailed statement of the work done and the results obtained. It is a detailed statement of the work done and the results obtained.

3. The third part of the report deals with the work done during the year. It is a detailed statement of the work done and the results obtained. It is a detailed statement of the work done and the results obtained.

4. The fourth part of the report deals with the work done during the year. It is a detailed statement of the work done and the results obtained. It is a detailed statement of the work done and the results obtained.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) <u>Morrison Edna M</u>				2. DATE OF DEATH 5/7/95 MONTH DAY YEAR		3. TIME OF DEATH 8:50 A M	
4. SOCIAL SECURITY NUMBER 235-14-2287		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 84 YRS.		7. DATE OF BIRTH 6-15-10 (Month, Day, Year)	
8. BIRTHPLACE (State or Foreign Country) West Virginia				9a. FACILITY NAME (If not institution, give street and number) Harbor Hospital Center		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore	
9c. COUNTY OF DEATH N.A.				10a. STATE Maryland		10b. COUNTY Baltimore	
10c. CITY, TOWN OR LOCATION Arbutus				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 921-915 Maiden Choice Lane	
10f. ZIP CODE 21229				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) _____				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Home Maker		16b. KIND OF BUSINESS/INDUSTRY Own Home	
17. FATHER'S NAME (First, Middle, Last) Larry Mayola				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ellen Jane Staggs			
19a. INFORMANT'S NAME (Type/Print) Ken Ireland				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 500 Penny Lane Cockeysville, Maryland 21030			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Glen Haven Memorial Park 5/10		20c. LOCATION — City or Town, State Glen Burnie, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Donna M. Zamisowski</u>				22. NAME AND ADDRESS OF FACILITY George J. Gonce Funeral Home P.A. 4001 Ritchie Hwy. Baltimore, Md. 21225			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastatic lung carcinoma DUE TO (OR AS A CONSEQUENCE OF): b. Dehydration DUE TO (OR AS A CONSEQUENCE OF): c. Chronic obstructive pulmonary disease DUE TO (OR AS A CONSEQUENCE OF): d. _____ Approximate Interval Between Onset and Death 2 months 1 week years							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <u>Donna M. Zamisowski</u> Home Staff				29c. LICENSE NUMBER AF 244161436		29d. DATE SIGNED (Month, Day, Year) 5/07/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) VANDERHART PAI HARBOR HOSPITAL CENTER							
31. DATE FILED (Month, Day, Year) MAY 08 1995				32. REGISTRAR'S SIGNATURE <u>John A. Davidson</u>			

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

4

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 13954

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) FRANKLIN E. MAY				2. DATE OF DEATH MONTH MAY DAY 2 YEAR 1995		3. TIME OF DEATH 120 P.M.		
4. SOCIAL SECURITY NUMBER 217 01 5082		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 76 YRS.		7. DATE OF BIRTH (Month, Day, Year) Oct. 31, 1918		
9a. FACILITY NAME (If not institution, give street and number) North Arundel Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Glen Burnie		9c. COUNTY OF DEATH Anne Arundel		
10a. STATE Maryland		10b. COUNTY Anne Arundel		10c. CITY, TOWN OR LOCATION Pasadena		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		
10e. STREET AND NUMBER 8585 Bay Road				10f. ZIP CODE 21122		10g. CITIZEN OF WHAT COUNTRY? U.S.A.		
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Steam Engineer		16b. KIND OF BUSINESS/INDUSTRY Chemical Plant				
17. FATHER'S NAME (First, Middle, Last) George Albert May				18. MOTHER'S NAME (First, Middle, Maiden Surname) Fredrica Sacks				
19a. INFORMANT'S NAME (Type/Print) Joyce Martinek				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 781 Evergreen Road Severn, Maryland 21144				
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Meadowridge Memorial Park 5/5		20c. LOCATION — City or Town, State Baltimore, Maryland		20d. DATE 5/5		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Chubane Horne				22. NAME AND ADDRESS OF FACILITY George J. Gonce Funeral Home P.A. 4001 Ritchie Hwy. Baltimore, Md. 21225				
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. HYPERCALEMIA IMMEDIATE CAUSE (Final disease or condition resulting in death) → ATRIAL FIBRILLATION, HYPERTENSION Approximate Interval Between Onset and Death 1 MONTH Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST CONGESTIVE HEART FAILURE DUE TO (OR AS A CONSEQUENCE OF): 1 MONTH DIABETES MELLITUS DUE TO (OR AS A CONSEQUENCE OF): 1 YEAR EMPHYSEMA CARCINOMA OF LUNG DUE TO (OR AS A CONSEQUENCE OF): 3 YEARS								
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>								
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. SIGNATURE AND TITLE OF CERTIFIER Dan H. Schreiner MD				29c. LICENSE NUMBER D28221		29d. DATE SIGNED (Month, Day, Year) May 2, 1995		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DAN H. SCHREINER, MD 301 HOSPITAL DRIVE, GLEN BURNIE, MARYLAND								
31. DATE FILED (Month, Day, Year) MAY 08 1995				32. REGISTRAR'S SIGNATURE John H. ...				

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13955

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Verna Pauline Malozi</i>				2. DATE OF DEATH MONTH DAY YEAR <i>May 3, 1995</i>		3. TIME OF DEATH HOURS MIN. SEC. <i>10:39 P M</i>	
4. SOCIAL SECURITY NUMBER <i>211-12-1992</i>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) YRS. MONTHS DAYS <i>77</i>		7. DATE OF BIRTH (Month, Day, Year) <i>Dec. 31, 1917</i>	
8. BIRTHPLACE (State or Foreign Country) <i>Pennsylvania</i>				9a. FACILITY NAME (If not institution, give street and number) <i>Franklin Square Hospital</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>Rossville</i>	
9c. COUNTY OF DEATH <i>Baltimore</i>				10a. STATE <i>Maryland</i>		10b. COUNTY <i>Baltimore</i>	
10c. CITY, TOWN OR LOCATION <i>Essex</i>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <i>14 Judywood Lane</i>	
10f. ZIP CODE <i>21221</i>				10g. CITIZEN OF WHAT COUNTRY? <i>United States</i>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>9 Years</i> College (1-4 or 5+) <i>College</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Housewife</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Own Home</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Horace King</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Carrie Ann Fisher</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Patric T. Jones</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>4620 White Avenue Baltimore, MD 21206</i>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of facility, crematory or other place) <i>Bel Air Memorial Gdns. 5/6/95</i>		20c. LOCATION — City or Town, State <i>Bel Air, Maryland</i>		21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Chad W. Fisher</i>	
22. NAME AND ADDRESS OF FACILITY <i>Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, MD 21222</i>				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>GI bleed</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. <i>Cancer</i> c. <i>Diabetes</i> d. <i>Renal insufficiency</i>			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Diabetes</i> <i>Renal insufficiency</i>				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>				25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined			
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY HOURS MIN. SEC. <i>M</i>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Michael D. Martin, M.D.</i>				29c. LICENSE NUMBER <i>D41968</i>		29d. DATE SIGNED (Month, Day, Year) <i>5/4/95</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>MICHAEL D. MARTIN, M.D. Baltimore, MD 21222</i>							
31. DATE FILED (Month, Day, Year) <i>MAY 08 1995</i>				32. REGISTRAR'S SIGNATURE <i>John H. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

NOTE: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

(E)

ALL INFORMATION CONTAINED
HEREIN IS UNCLASSIFIED

95 13956

Item, File #723,5/8/95,1t

1 - STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Mitchell</i> <i>WILHELMINA A. MITCHELL</i>			2. DATE OF DEATH MONTH DAY YEAR <i>05 04 95</i>		3. TIME OF DEATH <i>1020 P</i>
4. SOCIAL SECURITY NUMBER <i>212-09-1028</i>	5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <i>97</i> YRS.	7. DATE OF BIRTH (Month, Day, Year) <i>03/30/1898</i>	8. BIRTHPLACE (State or Foreign Country) <i>Maryland</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Biverview Nursing Centre</i>			9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore MD 21221</i>		9c. COUNTY OF DEATH <i>Baltimore</i>
10a. STATE <i>Md.</i>			10b. COUNTY <i>Baltimore</i>		10c. CITY, TOWN OR LOCATION <i>Essex</i>
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			10e. STREET AND NUMBER <i>1 Eastern Ave.</i>		
10f. ZIP CODE <i>21221</i>			10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:	
14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <i>Elementary/Secondary (9-12)</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Seamstress</i>		16b. KIND OF BUSINESS/INDUSTRY <i>I C Issacs</i>	
17. FATHER'S NAME (First, Middle, Last) <i>Charles Bodenburg</i>			18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Mary Maier</i>		
19a. INFORMANT'S NAME (Type/Print) <i>Thelma Adams</i>			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>202 Mars Ave. Southeast Winter Haven Florida</i>		
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Moreland Memorial 5/8/95</i>		20c. LOCATION — City or Town, State <i>Baltimore MD.</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>R. Terry Connelly</i>			22. NAME AND ADDRESS OF FACILITY <i>Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221</i>		
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Atherosclerotic Heart Disease</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.					Approximate Interval Between Onset and Death <i>20 years</i>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Dementia</i>					24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
					24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY <i>M</i>	28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURED			28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)		
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Michael Suter</i>			29c. LICENSE NUMBER <i>D44604</i>		29d. DATE SIGNED (Month, Day, Year) <i>5/5/95</i>
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Dr. Michael Suter Franklin Square Hospital</i>					
31. DATE FILED (Month, Day, Year) <i>MAY 08 1995</i>		32. REGISTRAR'S SIGNATURE <i>R. A. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

5

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

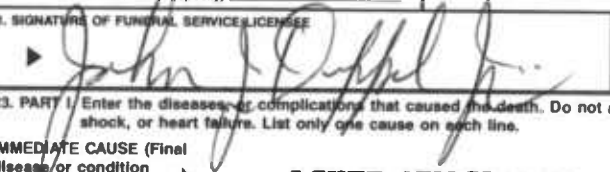

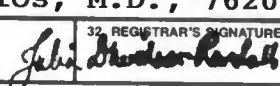
TO THE FUNERAL HOME: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13957

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) HALBERT WILLIAM MCMULLEN, SR.				2. DATE OF DEATH MONTH DAY YEAR MAY 5, 1995		3. TIME OF DEATH 6:10 A M	
4. SOCIAL SECURITY NUMBER 212-36-0628		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 56 YRS.		7. DATE OF BIRTH (Month, Day, Year) February 18, 1939	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) SAINT JOSEPH MEDICAL CENTER		9b. CITY, TOWN OR LOCATION OF DEATH TOWSON, MARYLAND	
9c. COUNTY OF DEATH BALTIMORE				10a. STATE MD		10b. COUNTY Harford	
10c. CITY, TOWN OR LOCATION Havre de Grace				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 421 Brian Garth	
10f. ZIP CODE 21078				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Truck Driver		16b. KIND OF BUSINESS/INDUSTRY Armored Trucking			
17. FATHER'S NAME (First, Middle, Last) Robert Lacey Mc Mullen				18. MOTHER'S NAME (First, Middle, Maiden Surname) Fannie Marie Clark			
19a. INFORMANT'S NAME (Type/Print) Darlene R. Mc Mullen				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 421 Brian Garth Havre de Grace, Maryland 21078			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of Parkwood Cemetery DATE 5/8/95		20c. LOCATION — City or Town, State Balto. MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY 7110 Belair Road The Dippel Funeral Home Inc. Baltimore, MD 21206			
23. PART I. Enter the disease or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ACUTE MYOCARDIAL INFARCTION DUE TO (OR AS A CONSEQUENCE OF): CORONARY ARTERY DISEASE Approximate Interval Between Onset and Death 6 DAYS Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. HYPERCHOLESTEROLEMIA DUE TO (OR AS A CONSEQUENCE OF): c. RHEUMATOID ARTHRITIS YEARS d. RHEUMATOID ARTHRITIS YEARS							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Peripheral Vascular Disease Right Total Hip Replacement for a vascular necrosis DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER  Lilia Ceballos, M.D.				29c. LICENSE NUMBER D25886		29d. DATE SIGNED (Month, Day, Year) 5.5.95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Lilia Ceballos, M.D., 7620 York Road, Towson, Maryland 21204							
31. DATE FILED (Month, Day, Year) MAY 08 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13958

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) GRACE MCDEARMON				2. DATE OF DEATH MONTH DAY YEAR MAY 5, 1995		3. TIME OF DEATH HOURS MIN P M 1:29 P M	
4. SOCIAL SECURITY NUMBER 406 09 2379		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 74 YRS.	7. DATE OF BIRTH (Month, Day, Year) July 1, 1920		8. BIRTHPLACE (State or Foreign Country) Ky.	
9a. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY		9c. COUNTY OF DEATH MD	
10a. STATE Md.		10b. COUNTY Carroll		10c. CITY, TOWN OR LOCATION Sykesville		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 6512 White Rock Road				10f. ZIP CODE 21784		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) H.S. College (1-4 or 5+) +2		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Registered Nurse		16b. KIND OF BUSINESS/INDUSTRY Hospital Health Care			
17. FATHER'S NAME (First, Middle, Last) William Taylor Shockey				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mattie Arnett			
19a. INFORMANT'S NAME (Type/Print) Fielding U. McDearmon				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) White 6512 Rock Rd. Sykesville, Md. 2127 21784			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Lake View Mem. Park May 9, 1995 Sykesville, Md.		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Harry W. Haight				22. NAME AND ADDRESS OF FACILITY Haight Funeral Home P.O. Box 195 Sykesville, Md. 21784			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Arctic Dissection Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death 5 hrs.
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER M. Boyd Gilligan				29c. LICENSE NUMBER 69834		29d. DATE SIGNED (Month, Day, Year) 5-5-95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) M. Boyd Gilligan, Johns Hopkins Hospital 600 W. Wolfe Street, Baltimore, MD							
31. DATE FILED (Month, Day, Year) MAY 8 1995							

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

F



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95 13959

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) CARL ARTHUR NICHOLSON				2. DATE OF DEATH MONTH DAY YEAR MAY 6 1995		3. TIME OF DEATH 2:26 A M	
4. SOCIAL SECURITY NUMBER 101-60-2421		5. SEX 1 M 2 F		6. AGE (In yrs. last birthday) 30 YRS.		7. DATE OF BIRTH (Month, Day, Year) MAY 4, 1965	
9a. FACILITY NAME (If not institution, give street and number) Stella Maris Hospice				9b. CITY, TOWN OR LOCATION OF DEATH Towson		9c. COUNTY OF DEATH Baltimore	
10a. STATE Maryland				10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION Baltimore	
10d. INSIDE CITY LIMITS? 1 X YES 2 NO				10e. STREET AND NUMBER 1001 St. Paul Street, Apt. 8-H			
10f. ZIP CODE 21202				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 X Never Married 2 Married 3 Widowed 4 Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 X NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 X NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Manager's Assistant		16b. KIND OF BUSINESS/INDUSTRY Restaurant			
17. FATHER'S NAME (First, Middle, Last) Harris Arthur Nicholson				18. MOTHER'S NAME (First, Middle, Maiden Surname) Solveig Patricia Pederson			
19a. INFORMANT'S NAME (Type/Print) Solveig Nelson				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6 Tyrconnell Ave. Massapequa Park, NY 11762			
20a. METHOD OF DISPOSITION 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory, Inc. 05/06/95		20c. LOCATION — City or Town, State Baltimore, MD		21. SIGNATURE OF FUNERAL SERVICE LICENSEE George E. MacNabb	
22. NAME AND ADDRESS OF FACILITY Cremation Society of Maryland 299 Frederick Rd. Baltimore, MD 21228		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Autoimmune Deficiency Syndrome 3 DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO						DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE					
27. MANNER OF DEATH 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 YES 2 NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Kendall R Faulkner				29c. LICENSE NUMBER D25643		29d. DATE SIGNED (Month, Day, Year) May 6, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. KENDALL FAULKNER 3300 DULANEY VALLEY RD. TOWSON, MD. 21204							
31. DATE FILED (Month, Day, Year) MAY 08 1995				32. REGISTRAR'S SIGNATURE Julia Davidson Kendall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13960

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) DOROTHY D. NELSON				2. DATE OF DEATH MONTH APRIL DAY 30 YEAR 1995		3. TIME OF DEATH 7 30 P M	
4. SOCIAL SECURITY NUMBER 220-22-4601		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 86 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 27, 1908	
8. BIRTHPLACE (State or Foreign Country) PENNSYLVANIA				9a. FACILITY NAME (If not institution, give street and number) Long Green Nursing Center		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore	
9c. COUNTY OF DEATH				10a. STATE Md			
10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Parkville		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 1701 ABERDEEN Rd	
10f. ZIP CODE 21234		10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: WHITE		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) —	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) MEDICAL SECRETARY				16b. KIND OF BUSINESS/INDUSTRY STATE of Maryland		17. FATHER'S NAME (First, Middle, Last) George P. Dodd	
18. MOTHER'S NAME (First, Middle, Maiden Surname) FRANCES M. MONTGOMERY				19a. INFORMANT'S NAME (Type/Print) FRANCES SMITH		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18601 GUN POWDER Rd. Hampstead Md 21074	
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Dulaney Valley Mem Gdns 5/4/95		20c. LOCATION — City or Town, State TIMONIUM, Md		21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Robert C. Quarsh</i>	
22. NAME AND ADDRESS OF FACILITY Evans Chapel of Chimes 2325 York Rd Timonium, Md 21093		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Atherosclerotic Cardiovascular Disease DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate interval Between Onset and Death: 6 months		PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Mellitus chronic Hypoxia congestive Heart Failure		24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO		25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER FREDERICK S. SIRKIS M.D.	
29c. LICENSE NUMBER D22645		29d. DATE SIGNED (Month, Day, Year) 5/2/95		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) FREDERICK S. SIRKIS M.D. 7151 HOLAN RD AVE.		31. DATE FILED (Month, Day, Year) MAY 08 1995	
32. REGISTRAR'S SIGNATURE <i>Julia...</i>		33. REGISTRAR'S TITLE		34. REGISTRAR'S SIGNATURE		35. REGISTRAR'S TITLE	

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: The law requires that the death certificate be completed and filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 23 is missing, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95-2566-510

L.R.B.

95 13961

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ERNEST OLIVER JR.				2. DATE OF DEATH MONTH DAY YEAR MAY 04 1995		3. TIME OF DEATH 12:40A	
4. SOCIAL SECURITY NUMBER 214-50-2130		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 49 YRS.		7. DATE OF BIRTH (Month, Day, Year) AUG 25, 1945	
8. BIRTHPLACE (State or Foreign Country) MARYLAND				9a. FACILITY NAME (If not institution, give street and number) SINAI HOSPITAL.		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City.	
9c. COUNTY OF DEATH N/A				10a. STATE MARYLAND			
10b. COUNTY N/A				10c. CITY, TOWN OR LOCATION BALTIMORE CITY			
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER 725 LYNDRHURST STREET			
10f. ZIP CODE 21229				10g. CITIZEN OF WHAT COUNTRY? USA.			
11. MARITAL STATUS <input checked="" type="checkbox"/> SINGLE <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11TH GRADE College (1-4 or 5+) N/A				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) MAINTENANCE WORKER		16b. KIND OF BUSINESS/INDUSTRY SOCIAL SECURITY ADM.	
17. FATHER'S NAME (First, Middle, Last) ERNEST OLIVER SR.				18. MOTHER'S NAME (First, Middle, Maiden Surname) WILLIE MAE FLOOD			
19a. INFORMANT'S NAME (Type/Print) DIANE PAGE				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 725 LYNDRHURST STREET, BALTO, MD. 21229			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) ARBUTUS CEMETERY 5-8-95 ARBUTUS, MD.		20c. LOCATION — City or Town, State		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY JOSEPH H. BROWN JR FUNERAL HOME, P.A. 1913 W. BALTIMORE ST., BALTIMORE, MD. 21223			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. GUNSHOT WOUND TO CHEST DUE TO (OR AS A CONSEQUENCE OF):							
b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) 5/4/95		28b. TIME OF INJURY 0011A		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURED SUBJECT SHOT		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) BUS STOP		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 4600 LIBERTY HTS AVE, BALTIMORE MD			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) MAY 04, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARIO F. GOLTO JR. 11 Penn Street, Baltimore, Maryland 21201.							
31. DATE FILED (Month, Day, Year) MAY 08 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

BALTIMORE, MARYLAND 21215-0020

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



(E)



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95 13962

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Roberta Phillips				2. DATE OF DEATH MONTH DAY YEAR May 01 1995		3. TIME OF DEATH 12:40 A M	
4. SOCIAL SECURITY NUMBER 217-01-0007		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 84 YRS.		7. DATE OF BIRTH (Month, Day, Year) 08/22/10	
8. FACILITY NAME (If not institution, give street and number) BON SECOUR HOSPITAL				9. CITY, TOWN OR LOCATION OF DEATH BALTIMORE		10. COUNTY OF DEATH N/A	
11. RESIDENCE OF DECEDENT 10a. STATE MARYLAND 10b. COUNTY N/A 10c. CITY, TOWN OR LOCATION BALTIMORE 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 3202 DORITHAN Rd.		10f. ZIP CODE 21215	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Domestic		16b. KIND OF BUSINESS/INDUSTRY HOME			
17. FATHER'S NAME (First, Middle, Last) MICHAEL JOHNSON				18. MOTHER'S NAME (First, Middle, Maiden Surname) LUCY BYRD			
19a. INFORMANT'S NAME (Type/Print) MARGARET SMITH				19b. MAILING ADDRESS (Street and Number or Rural Route Number City or Town, State, Zip Code) 3202 DORITHAN Rd. BALTO. MD 21215			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) WESTERN STAR 5/5/95		20c. LOCATION — City or Town, State BALTIMORE MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Derrick C. Jones				22. NAME AND ADDRESS OF FACILITY DERRICK C. JONES FUNERAL HOME 4611 PARK HEIGHTS AVE. BALTO. MD 21215			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiovascular and respiratory arrest DUE TO (OR AS A CONSEQUENCE OF): b. Septic shock DUE TO (OR AS A CONSEQUENCE OF): c. Cerebrovascular accident DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) N/A		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER J. P. Jones				29c. LICENSE NUMBER D18484		29d. DATE SIGNED (Month, Day, Year) 5/2/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) HOSSEIN TAVASSOLIE MD. 3455 WILKENS AVE #306 BALTO MD 21229							
31. DATE FILED (Month, Day, Year) MAY 08 1995		32. REGISTRAR'S SIGNATURE Juli Anderson					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 23 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13963

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) LESTER PACK				2. DATE OF DEATH MONTH MAY DAY 2 , YEAR 1995		3. TIME OF DEATH 11:55 P M	
4. SOCIAL SECURITY NUMBER 216-40-1272		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 52 YRS.		7. DATE OF BIRTH (Month, Day, Year) APRIL 2, 1943	
8. BIRTHPLACE (State or Foreign Country) MARYLAND				9a. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City	
9c. COUNTY OF DEATH N/A				10a. STATE MARYLAND		10b. COUNTY N/A	
10c. CITY, TOWN OR LOCATION BALTIMORE CITY				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 501 E. PRESTON STREET, APT.#503	
10f. ZIP CODE 21202				10g. CITIZEN OF WHAT COUNTRY? USA.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9th GRADE College (14 or 5+) LABORER				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) LABORER		16b. KIND OF BUSINESS/INDUSTRY AERO SPACE COMPANY	
17. FATHER'S NAME (First, Middle, Last) UNKNOWN				18. MOTHER'S NAME (First, Middle, Maiden Surname) MILDRED PACK			
19a. INFORMANT'S NAME (Type/Print) JOSEPH PACK				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9316 TULSEMERE ROAD, RANDALSTOWN, MD. 21133			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) KING MEMORIAL PARK CEMETERY 5-5-95 WOODLAWN, MARYLAND		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY JOSEPH H. BROWN JR FUNERAL HOME, P.A. 1913 W. BALTIMORE ST., BALTIMORE, MD. 21223			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Renal Failure DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. Prolonged Anoxia DUE TO (OR AS A CONSEQUENCE OF): c. Respiratory Arrest DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death 1 month 1 month 1 month							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Persistent Neurologic Vegetative State							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER J. A. Underwood, M.D.				29c. LICENSE NUMBER M6175		29d. DATE SIGNED (Month, Day, Year) 5-2-95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J. A. Underwood, M.D., Johns Hopkins Hospital, Baltimore, MD							
31. DATE FILED (Month, Day, Year) MAY 08 1995				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13964

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) CHRISTOPHER WILSON PETRATOS				2. DATE OF DEATH MONTH DAY YEAR MAY 8, 1995		3. TIME OF DEATH 12:20 A. M	
4. SOCIAL SECURITY NUMBER 229-46-2117		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 56 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) MAY 28, 1938	
9a. FACILITY NAME (If not institution, give street and number) 13202 SANDSTON COURT				9b. CITY, TOWN OR LOCATION OF DEATH LAUREL		9c. COUNTY OF DEATH PRINCE GEORGE	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY PRINCE GEORGE		10c. CITY, TOWN OR LOCATION LAUREL		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 13202 SANDSTON COURT				10f. ZIP CODE 20708		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1958 - 1960		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) 12 0				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CLERK		16b. KIND OF BUSINESS/INDUSTRY RETAIL	
17. FATHER'S NAME (First, Middle, Last) SAMUEL JOHN PETRATOS				18. MOTHER'S NAME (First, Middle, Maiden Surname) CARRIE ELIZABETH HOWARD			
19a. INFORMANT'S NAME (Type/Print) PATRICIA A. PETRATOS				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13202 SANDSTON COURT LAUREL MARYLAND 20708			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) BALTIMORE WASHINGTON CREMATORY		DATE 5/8		20c. LOCATION — City or Town, State LAUREL, MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY FLECK FUNERAL HOME, INC. 7601 SANDY SPRING ROAD, LAUREL, MD. 20707			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Dementia with central nervous system insufficiency</u> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>immune deficiency</u>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Martin O. Weitz</i>				29c. LICENSE NUMBER D23743		29d. DATE SIGNED (Month, Day, Year) 5-8-95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARTIN WEITZ 3525 Greenway CTR DR GREENBELT MD 20770							
31. DATE FILED (Month, Day, Year) MAY 08 1995							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.


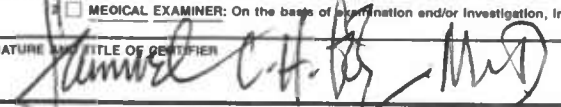
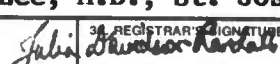
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13965

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) EDWARD L RITTER SR.				2. DATE OF DEATH MONTH MAY DAY 1 YEAR 1995		3. TIME OF DEATH 7:00 P.M.		
4. SOCIAL SECURITY NUMBER 215-01-8592		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 78 YRS.		7. DATE OF BIRTH (Month, Day, Year) DEC 21, 1916		8. BIRTHPLACE (State or Foreign Country) MARYLAND	
9a. FACILITY NAME (If not institution, give street and number) SAINT JOSEPH MEDICAL CENTER				9b. CITY, TOWN OR LOCATION OF DEATH TOWSON, MARYLAND		9c. COUNTY OF DEATH BALTIMORE		
10a. STATE MD.				10b. COUNTY BALTIMORE		10c. CITY, TOWN OR LOCATION PARKVILLE		
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 9622 1/2 HARDING AVE		10f. ZIP CODE 21234		
10g. CITIZEN OF WHAT COUNTRY? USA				11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII		
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: WHITE				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) —				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CARPENTER		16b. KIND OF BUSINESS/INDUSTRY Carpenter Union Local 101		
17. FATHER'S NAME (First, Middle, Last) HENRY H. RITTER				18. MOTHER'S NAME (First, Middle, Maiden Surname) ALICE M. MORGAN				
19a. INFORMANT'S NAME (Type/Print) ELIZABETH RITTER				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9622 1/2 HARDING AVE Balto. Md. 21234				
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) DULANEY VALLEY MEMORIALS 5/5/95		20c. LOCATION — City or Town, State TIMONIUM, Md.		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY EVANS Chapel of Memories 8800 Harford Rd Baltimore, Md 21234				
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
IMMEDIATE CAUSE (Final disease or condition resulting in death) →								
a. RESPIRATORY INSUFFICIENCY DUE TO (OR AS A CONSEQUENCE OF):								
b. MALIGNANCY NEOPLASM INVOLVING LUNG DUE TO (OR AS A CONSEQUENCE OF):								
c. WITH METASTASIS DUE TO (OR AS A CONSEQUENCE OF):								
d.								
23. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HISTORY OF ASBESTOS EXPOSURE								
24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO								
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO								
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO								
26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) HOSPICE								
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined								
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. SIGNATURE AND TITLE OF CERTIFIER  Samuel C. H. Lee, M.D.				29c. LICENSE NUMBER D06234		29d. DATE SIGNED (Month, Day, Year) 5/2/95		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Samuel C. H. Lee, M.D., St. Joseph Medical Ctr., Towson, Md. 21204								
31. DATE FILED (Month, Day, Year) MAY 08 1995				32. REGISTRAR'S SIGNATURE 				

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.


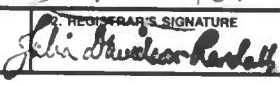
TO THE FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If the death is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13966

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Joseph Rome</u>				2. DATE OF DEATH MONTH <u>4</u> DAY <u>27</u> YEAR <u>95</u>		3. TIME OF DEATH <u>9:50 AM</u>	
4. SOCIAL SECURITY NUMBER <u>284-10-6036</u>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>82</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>JUNE 2, 1912</u>	
8. BIRTHPLACE (State or Foreign Country) <u>CZECHOSLOVAKIA</u>				9a. FACILITY NAME (If not institution, give street and number) <u>GOLDEN OAKS NURSING HOME</u>		9b. CITY, TOWN OR LOCATION OF DEATH <u>LAUREL</u>	
9c. COUNTY OF DEATH <u>PRINCE GEORGE</u>				10a. STATE <u>MARYLAND</u>		10b. COUNTY <u>HOWARD</u>	
10c. CITY, TOWN OR LOCATION <u>LAUREL</u>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <u>9103 TYMAT COURT</u>	
10f. ZIP CODE <u>20723</u>				10g. CITIZEN OF WHAT COUNTRY? <u>USA</u>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— if yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>WHITE</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u>0</u>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>MINER</u>		16b. KIND OF BUSINESS/INDUSTRY <u>MINING</u>	
17. FATHER'S NAME (First, Middle, Last) <u>CYRIL ROME</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>HELEN PROSEK</u>			
19a. INFORMANT'S NAME (Type/Print) <u>GERALD RUEHL</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>9103 TYMAT COURT, LAUREL, MARYLAND 20723</u>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>BALTIMORE WASHINGTON CREMATORY</u> DATE <u>4/28</u>		20c. LOCATION — City or Town, State <u>LAUREL, MARYLAND</u>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <u>FLECK FUNERAL HOME, INC.</u> <u>7601 SANDY SPRING ROAD, LAUREL, MARYLAND 20707</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>a. Coronary Artery Disease</u> DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Chronic Obstructive Pulmonary Disease</u> <u>Hypertension</u> <u>Dementia</u>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <u>M</u>	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <u>H. B. Jones MD</u>				29c. LICENSE NUMBER <u>D23181</u>		29d. DATE SIGNED (Month, Day, Year) <u>5-2-95</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>R.G. BHOTRAJ, MD 704 Gorman Ave #T-1 Laurel, MD 20707</u>							
31. DATE FILED (Month, Day, Year) <u>MAY 08 1995</u>				32. REGISTRAR'S SIGNATURE 			

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

95 13967

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) James Alvin RICHMOND				2. DATE OF DEATH MONTH DAY YEAR May 4, 1995		3. TIME OF DEATH 12:45 p.m.	
4. SOCIAL SECURITY NUMBER 233-14-2789		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 78 YRS.	7. DATE OF BIRTH (Month, Day, Year) Jan. 26, 1917		8. BIRTHPLACE (State or Foreign Country) West Virginia	
9a. FACILITY NAME (If not institution, give street and number) Franklin Square Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Rossville		9c. COUNTY OF DEATH Baltimore County	
10a. STATE Md.		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Essex		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 502 North Woodward Drive				10f. ZIP CODE 21221		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Shipping		16b. KIND OF BUSINESS/INDUSTRY Glen L. Martin			
17. FATHER'S NAME (First, Middle, Last) Alvin Wesley Richmond				18. MOTHER'S NAME (First, Middle, Maiden Surname) Minte Crook			
19a. INFORMANT'S NAME (Type/Print) Connie Reinecke				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2151 Carrs Mill Road Fallston Md. 21047			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Oak Lawn Cemetery 5/6/95		20c. LOCATION — City or Town, State Baltimore Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE R. Terry Connelly				22. NAME AND ADDRESS OF FACILITY Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Urosepsis DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. Diabetes DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate interval Between Onset and Death 4 days 10 years
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER Karen Leber		29c. LICENSE NUMBER D45979		29d. DATE SIGNED (Month, Day, Year) 5/4/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Karen Leber, M.D. 9000 Franklin Square Drive, Baltimore, MD 21237							
31. DATE FILED (Month, Day, Year) MAY 08 1995				32. REGISTRAR'S SIGNATURE John D. ...			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

4

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Electrolysis 2022

95 13968

ITEMS: 4.6.7.8.15-18, PER F.H. FILM G-723 5/8/95 t.t
 FOR
 1. STATE REGISTRAR
 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH
 REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JOAN ELIZABETH ROONEY SULLIVAN				2. DATE OF DEATH May 4, 1995		3. TIME OF DEATH 7:15 P M	
4. SOCIAL SECURITY NUMBER 357-22-0640		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 64 YRS.		7. DATE OF BIRTH (Month, Day, Year) 7-11-30	
8. BIRTHPLACE (State or Foreign Country) CHICAGO, ILL.		9a. FACILITY NAME (If not institution, give street and number) 5137 Bonnie Branch Road		9b. CITY, TOWN OR LOCATION OF DEATH Ellicott City		9c. COUNTY OF DEATH Howard County	
10a. STATE Maryland		10b. COUNTY Howard County		10c. CITY, TOWN OR LOCATION Ellicott City		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 5137 Bonnie Branch Road				10f. ZIP CODE 21043		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4 years		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER		16b. KIND OF BUSINESS/INDUSTRY OWN HOME			
17. FATHER'S NAME (First, Middle, Last) DANIEL ROONEY				18. MOTHER'S NAME (First, Middle, Maiden Surname) MARY ELIZABETH CASEY			
19a. INFORMANT'S NAME (Type/Print) Mr. Peter L. Sullivan				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5137 Bonnie Branch Road, Ellicott City, MD 21043			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium or other place) Baltimore-Washington Crematory 5/5/95		20c. LOCATION — City or Town, State Laurel, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Philip Sullivan</i> M00535				22. NAME AND ADDRESS OF FACILITY Slack Funeral Home, P.A. Ellicott City, Maryland 21043			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Extensive Stage Small Cell Lung Cancer 1 year DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>CPA T. W. ...</i>				29c. LICENSE NUMBER 241139.		29d. DATE SIGNED (Month, Day, Year) 5/5/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 11065 Little Bluestem Parkway, Columbia, Md.							
31. DATE FILED (Month, Day, Year) MAY 08 1995				32. REGISTERED PHYSICIAN'S SIGNATURE <i>John ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR AFTER DEATH: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
 TO THE FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Handwritten text at the bottom center, possibly a date or signature, which is mostly illegible due to fading.

95 13969

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Walter F. Smith				2. DATE OF DEATH MONTH DAY YEAR April 29 1995		3. TIME OF DEATH 1514 P M	
4. SOCIAL SECURITY NUMBER 218-01-6243 A		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 77 YRS.		7. DATE OF BIRTH (Month, Day, Year) Dec 31, 1917	
8. BIRTHPLACE (State or Foreign Country) Md		9a. FACILITY NAME (If not institution, give street and number) University Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Balto		9c. COUNTY OF DEATH Balto	
10a. STATE md				10b. COUNTY		10c. CITY, TOWN OR LOCATION Balto	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER 1010 W. Baltimore st.		10f. ZIP CODE 21223	
10g. CITIZEN OF WHAT COUNTRY? U.S.A				11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: Black		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 5th College (14 or 5+) NA	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Chauffeur				16b. KIND OF BUSINESS/INDUSTRY Provident Saving Bank			
17. FATHER'S NAME (First, Middle, Last) William Smith				18. MOTHER'S NAME (First, Middle, Maiden Surname) Lottie Ringgold			
19a. INFORMANT'S NAME (Type/Print) Ethel Smith				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1010 W. Balto st. Balto, md 21223			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory 5/5/95		20c. LOCATION — City or Town, State Cottonville, md	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Gladys Warner				22. NAME AND ADDRESS OF FACILITY March FH - West 4300 Wabash Ave			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
a. Congestive Heart Failure. DUE TO (OR AS A CONSEQUENCE OF):							
b. Renal Failure. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension, Dilated Cardiomyopathy							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> 4 Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> 6 Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Nomicide 7 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Michael Fisher MD				29c. LICENSE NUMBER D15317		29d. DATE SIGNED (Month, Day, Year) 4/30/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MICHAEL L. FISHER MD UNIVERSITY OF MARYLAND HOSPITAL 22 S. GREENE ST. BALTIMORE, MD 21201							
31. DATE FILED (Month, Day, Year) MAY 08 1995				REGISTRAR'S SIGNATURE John H. Harkins			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13970

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) THOMAS JOSEPH SPETZLER				2. DATE OF DEATH MONTH APRIL DAY 27 YEAR 1995		3. TIME OF DEATH 11:45 P.M.	
4. SOCIAL SECURITY NUMBER 219-56-2749		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 44 YRS.		7. DATE OF BIRTH (Month, Day, Year) JULY 1, 1950	
9a. FACILITY NAME (If not institution, give street and number) 4607 PARKWOOD AVE.				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE		9c. COUNTY OF DEATH N/A	
10a. STATE MARYLAND				10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION BALTIMORE	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER 4607 PARKWOOD AVE.		10f. ZIP CODE 21206	
10g. CITIZEN OF WHAT COUNTRY? U.S.A.				11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES VIETNAM	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: WHITE			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 YRS College (1-4 or 5+) College				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) BUYER			
16b. KIND OF BUSINESS/INDUSTRY STATE OF MARYLAND				17. FATHER'S NAME (First, Middle, Last) FRANCIS H. SPETZLER, SR.			
18. MOTHER'S NAME (First, Middle, Maiden Surname) Rosalie C. Reott				19. INFORMANT'S NAME (Type/Print) Rosalie C. Spetzer			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GARRISON FOREST 5/31			
20c. LOCATION — City or Town, State GARRISON, MARYLAND				21. SIGNATURE OF FUNERAL SERVICE LICENSEE [Signature]			
22. NAME AND ADDRESS OF FACILITY EVANS CHAPEL OF MEMORIES 8800 HARFORD ROAD - PARKVILLE				23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Metastatic gastric carcinoma DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. 3 months			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO				25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER Matilda H. Spetzer				29c. LICENSE NUMBER D26250		29d. DATE SIGNED (Month, Day, Year) APR 28, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MATILDA H. Spetzer 1447 York Road - Lutherville, MD				31. DATE FILED (Month, Day, Year) MAY 08 1995			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 23 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95-2567-510

L.R.B.

95 13971

1. FOR
STATE
REGISTRAR

Item 6a, Film 723, 5/8/95 1t

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) RICHARD LAWRENCE SEESE, SR.				2. DATE OF DEATH MONTH MAY DAY 04 YEAR 1995		3. TIME OF DEATH 3:59A M	
4. SOCIAL SECURITY NUMBER 220 66 0862		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 36 YRS.		7. DATE OF BIRTH (Month, Day, Year) 10 26 58	
9a. FACILITY NAME (If not institution, give street and number) BAYVIEW HOSPITAL.				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City.		9c. COUNTY OF DEATH N/A	
RESIDENCE OF DECEDENT							
10a. STATE Md.		10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 6311 Hudson Street				10f. ZIP CODE 21224		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 8 College (1-4 or 5+) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Richar Welder		16b. KIND OF BUSINESS/INDUSTRY Fence Co.			
17. FATHER'S NAME (First, Middle, Last) Richard E. Seese				18. MOTHER'S NAME (First, Middle, Maiden Surname) Helen P. Gibson			
19a. INFORMANT'S NAME (Type/Print) Deborah Fraska				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12515 Belair Rd. Kingsville, Md. 21087			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Green Mount Crematory		DATE 5-8-95		20c. LOCATION — City or Town, State Balto., Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Charles S. Zeiler				22. NAME AND ADDRESS OF FACILITY Charles S. Zeiler & Son Inc. 6224c Eastern Ave. Balto., Md.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. GUNSHOT WOUND TO CHEST DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) 5/4/95		28b. TIME OF INJURY 0224AM		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED SUBJECT SHOT		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) 1400 ANGLESEA, BALTIMORE MD			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER Charles S. Zeiler		29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) MAY 04, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARIO F. GOLKE JR MD 111 Penn Street, Baltimore, Maryland 21201.							
31. DATE FILED (Month, Day, Year) MAY 08 1995		32. REGISTRAR'S SIGNATURE [Signature]					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13972

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) James Robert Slavy				2. DATE OF DEATH MONTH DAY YEAR May 05 1995		3. TIME OF DEATH 7:30 P. M.	
4. SOCIAL SECURITY NUMBER 234 22 1904		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 79 YRS.		7. DATE OF BIRTH (Month, Day, Year) Sept. 2, 1915	
9a. FACILITY NAME (If not institution, give street and number) 740 Old Riverside Road				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH Anne Arundel	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Anne Arundel		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 740 Old Riverside Road				10f. ZIP CODE 21225		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES World War II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yee or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) 11th		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Electrician		16b. KIND OF BUSINESS/INDUSTRY General Motors			
17. FATHER'S NAME (First, Middle, Last) Aaron Franklin Slavy				18. MOTHER'S NAME (First, Middle, Maiden Surname) Amanda Cooper			
19a. INFORMANT'S NAME (Type/Print) Betty Slavy				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 740 Old Riverside Road Baltimore, Maryland 21225			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Md. State Veterans Cem. 5/8		20c. LOCATION — City or Town, State Crownsville, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Jerome Znamenski</i>				22. NAME AND ADDRESS OF FACILITY George J. Gonce Funeral Home P.A. 4001 Ritchie Hwy. Baltimore, Md. 21225			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Metastatic Carcinoma liver DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Markan M.D.</i>		29c. LICENSE NUMBER D39505		29d. DATE SIGNED (Month, Day, Year) 5/7/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) YUDHISHTRA MARKAN M.D. 1720 Cray Glen Pkwy #204, Glen Burnie, MD 21061							
31. DATE FILED (Month, Day, Year) MAY 08 1995		32. REGISTRAR'S SIGNATURE <i>Jebi...</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13973

ITEMS: 9a,10c,10e,10f,15,16a,17,18, PER INFORMANT FILM G-731 1/19/96 t.t

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Ingeborg Strausbaugh</i>				2. DATE OF DEATH MONTH DAY YEAR <i>May 3, 1995</i>		3. TIME OF DEATH YEAR <i>6:25A</i>	
4. SOCIAL SECURITY NUMBER <i>220-74-7065</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>56</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>Jan. 13, 1939</i>	
9a. FACILITY NAME <i>DOCTORS COMMUNITY HOSPITAL</i> Doctor's Hospital				9b. CITY, TOWN OR LOCATION OF DEATH <i>Lanham</i>		9c. COUNTY OF DEATH <i>Prince George</i>	
10a. STATE <i>Maryland</i>				10b. COUNTY <i>Prince George</i>		10c. CITY, TOWN OR LOCATION Riverdale <i>NEW CARROLLTON</i>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <i>7605 Riverdale Road #337 APT. 402</i>			
10f. ZIP CODE 20737 <i>20784</i>				10g. CITIZEN OF WHAT COUNTRY? <i>Germany</i>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>9</i> College (1-4 or 5+) <i>3</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Tailor AND HOUSEWIFE</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Clothing</i>			
17. FATHER'S NAME (First, Middle, Last) <i>JUSTUS AUBEL</i> Justus Strausbaugh				18. MOTHER'S NAME <i>HERMINE ELISABETH AUBEL nee PRIESTER</i> Hermine Priester			
19a. INFORMANT'S NAME (Type/Print) <i>Andree L. Strausbaugh</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>313 Oakmanor Drive #103, Glen Burnie, MD 21061</i>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Baltimore Washington Crem 5/4</i>		20c. LOCATION — City or Town, State <i>Laurel, Maryland</i>		21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Clare D. Leary</i>	
22. NAME AND ADDRESS OF FACILITY <i>Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Laurel, MD 20707</i>		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>a. Metastatic Adenocarcinoma to Liver</i> DUE TO (OR AS A CONSEQUENCE OF): <i>Adenocarcinoma</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Coagulopathy</i>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John S. Feldman</i>				29c. LICENSE NUMBER <i>TD32261</i>		29d. DATE SIGNED (Month, Day, Year) <i>5-3-95</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>John S. Feldman MD 9500 Annapolis Rd Washington MD</i>							
31. DATE FILED (Month, Day, Year) <i>MAY 08 1995</i>				32. REGISTRAR'S SIGNATURE <i>John S. Feldman</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) LORETTA THOMAS				2. DATE OF DEATH MONTH DAY YEAR MAY 5, 1995		3. TIME OF DEATH 3:23 P M	
4. SOCIAL SECURITY NUMBER 220-20-3396		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 67 YRS.		7. DATE OF BIRTH (Month, Day, Year) May 2, 1928	
8. BIRTHPLACE (State or Foreign Country) Maryland				9. FACILITY NAME (If not institution, give street and number) 1919 RIDGEHILL AVENUE		10. CITY, TOWN OR LOCATION OF DEATH BALTIMORE	
11. RESIDENCE OF DECEDENT 10a. STATE Maryland 10b. COUNTY N/A 10c. CITY, TOWN OR LOCATION Baltimore				12. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13. CITIZEN OF WHAT COUNTRY? USA	
14. STREET AND NUMBER 1919 Ridgehill Ave.				15. ZIP CODE 21217		16. KIND OF BUSINESS/INDUSTRY Own Home	
17. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		18. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		19. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		20. RACE — American Indian, Black, White, etc. Specify: Black	
21. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0				22. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		23. KIND OF BUSINESS/INDUSTRY Own Home	
24. FATHER'S NAME (First, Middle, Last) Bernard Ward				25. MOTHER'S NAME (First, Middle, Maiden Surname) Myrtle Ward			
26. INFORMANT'S NAME (Type/Print) Michael Rivers				27. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1904 Walbrook Ave. Balto, Md. 21217			
28. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		29. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium or other place) Mt. Zion 5/11/95		30. LOCATION — City or Town, State Lansdowne, Md.		31. SIGNATURE OF FUNERAL SERVICE LICENSEE Joseph L. Russ	
32. NAME AND ADDRESS OF FACILITY Joseph L. Russ Funeral Home 2222 W. North Ave. Balto, Md. 21216				33. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Hypertensive Arteriosclerotic Cardiovascular Disease DUE TO (OR AS A CONSEQUENCE OF):			
34. SEQUENTIALLY list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST				35. DUE TO (OR AS A CONSEQUENCE OF):			
36. DUE TO (OR AS A CONSEQUENCE OF):				37. DUE TO (OR AS A CONSEQUENCE OF):			
38. DUE TO (OR AS A CONSEQUENCE OF):				39. DUE TO (OR AS A CONSEQUENCE OF):			
40. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				41. 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
42. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>				43. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
44. 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		45. 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		46. 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		47. 28a. DATE OF INJURY (Month, Day, Year)	
48. 28b. TIME OF INJURY M		49. 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		50. 28d. DESCRIBE NOW INJURY OCCURRED		51. 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
52. 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		53. 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		54. 29b. SIGNATURE AND TITLE OF CERTIFIER Donald G. Wright MD		55. 29c. LICENSE NUMBER O.C.M.E.	
56. 29d. DATE SIGNED (Month, Day, Year) MAY 6, 1995		57. 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DONALD G. WRIGHT M.D. 111 Penn Street, Baltimore, Maryland 21201		58. 31. DATE FILED (Month, Day, Year) MAY 8 1995		59. 32. REGISTRAR'S SIGNATURE John Andrew Randall	

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13975

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) KYLE DRAPER TROXEL				2. DATE OF DEATH MONTH DAY YEAR May 1, 1995		3. TIME OF DEATH 9:02 a.m.	
4. SOCIAL SECURITY NUMBER 229 01 4312		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (in yrs. last birthday) 89 YRS.		7. DATE OF BIRTH (Month, Day, Year) APRIL 7 1906	
8. BIRTHPLACE (State or Foreign Country) VIRGINIA				9a. FACILITY NAME (If not institution, give street and number) GREATER BALTIMORE MEDICAL CENTER		9b. CITY, TOWN OR LOCATION OF DEATH TOWSON	
9c. COUNTY OF DEATH BALTIMORE				10a. STATE MARYLAND		10b. COUNTY BALTIMORE	
10c. CITY, TOWN OR LOCATION Monkton				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 814 Monkton Road	
10f. ZIP CODE 21111				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: WHITE				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4 yrs College (1-4 or 5+) College			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CARPENTER				16b. KIND OF BUSINESS/INDUSTRY CONSTRUCTION			
17. FATHER'S NAME (First, Middle, Last) George Robert Troxel				18. MOTHER'S NAME (First, Middle, Maiden Surname) MYRTLE OKANAH MERCER			
19a. INFORMANT'S NAME (Type/Print) Doris Troxel				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 814 Monkton Road Monkton, Maryland 21111			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Duane Valley Memorial 5-5-95			
20c. LOCATION — City or Town, State Timonium, Maryland				21. SIGNATURE OF FUNERAL SERVICE LICENSEE [Signature]			
22. NAME AND ADDRESS OF FACILITY EVANS CHAPEL OF CHIMES 2225 YORK ROAD - Timonium				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. Ventricular fibrillation DUE TO (OR AS A CONSEQUENCE OF): b. Acute Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF): c. ASCVD c Coronary artery disease DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death 1 min 1-3 hrs. years			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year) May 1, 1995			
28b. TIME OF INJURY M				28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER Mark S. Kaplan M.D.				29c. LICENSE NUMBER P19155			
29d. DATE SIGNED (Month, Day, Year) 5/2/95				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARK S. KAPLAN M.D. 16924 YORK RD. MONKTON MD 21111			
31. DATE FILED (Month, Day, Year) MAY 08 1995				32. REGISTRAR'S SIGNATURE John Andrew Radell			

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

10

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.


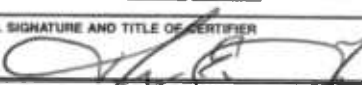
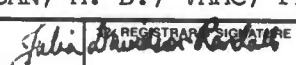
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 23 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13976

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) HAROLD C. ULREY				2. DATE OF DEATH MONTH DAY YEAR April 29, 1995		3. TIME OF DEATH 7:00A M	
4. SOCIAL SECURITY NUMBER 317-16-1965		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 67 YRS.		7. DATE OF BIRTH (Month, Day, Year) OCT 29, 1927	
9a. FACILITY NAME (If not institution, give street and number) Perry Point Medical Center				9b. CITY, TOWN OR LOCATION OF DEATH Perryville		9c. COUNTY OF DEATH CECIL	
RESIDENCE OF DECEDENT							
10a. STATE Md.		10b. COUNTY Harford		10c. CITY, TOWN OR LOCATION ABBINGDON		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10a. STREET AND NUMBER 3428 WINTER MOSS CT.				10f. ZIP CODE 21009		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Defense INSPECTOR		16b. KIND OF BUSINESS/INDUSTRY US Government	
17. FATHER'S NAME (First, Middle, Last) IVAN ULREY				16. MOTHER'S NAME (First, Middle, Maiden Surname) Emma ETHEL PERKINS			
19a. INFORMANT'S NAME (Type/Print) RINA L. ULREY				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3428 Winter Moss Ct. ABBINGDON, Md. 21009			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MORELAND MEMORIAL		DATE 5/4/95		20c. LOCATION — City or Town, State Parkville Md	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY EVANS CHAPEL OF MEMORIES 8800 Harford Rd. Balto. Md. 21234			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pneumonia DUE TO (OR AS A CONSEQUENCE OF): b. Alzheimer's Disease DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Coronary artery disease							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D32395		29d. DATE SIGNED (Month, Day, Year) 4-29-95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) THOMAS FINUCAN, M. D., VAMC, PERRY POINT, MD., 21902							
31. DATE FILED (Month, Day, Year) MAY 08 1995		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 5 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director.

IMPORTANT: Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13977

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) GEORGE LEROY VICKROY				2. DATE OF DEATH MONTH MAY DAY 6 , YEAR 1995		3. TIME OF DEATH 8:10P M	
4. SOCIAL SECURITY NUMBER 181-18-5066		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 70 YRS.		7. DATE OF BIRTH (Month, Day, Year) 5/14/24	
9a. FACILITY NAME (If not institution, give street and number) VAMC, FORT HOWARD, MD. 21052				9b. CITY, TOWN OR LOCATION OF DEATH FORT HOWARD		9c. COUNTY OF DEATH BAITIMORE	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY BALTIMORE		10c. CITY, TOWN OR LOCATION BALTIMORE		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 258 HENRIETTA AVE.				10f. ZIP CODE 21221		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) DISABILITY		16b. KIND OF BUSINESS/INDUSTRY DISABLED			
17. FATHER'S NAME (First, Middle, Last) CONRAD H. VICKROY				18. MOTHER'S NAME (First, Middle, Maiden Surname) ELSIE HILLMAN			
19a. INFORMANT'S NAME (Type/Print) MARION I. BALDWIN				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4437 Mountain Rd. Apt. 3 Pasadena, Maryland 21122			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MARYLAND VETERANS CEM 5/12/1995 CROWNSVILLE, MD		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Hillary L. Stallings Jr.				22. NAME AND ADDRESS OF FACILITY STALLINGS FUNERAL HOME P.A. 3111 Mountain Road Pasadena, Maryland 21122			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. Paraplegia Secondary Cervical Disc Disease DUE TO (OR AS A CONSEQUENCE OF):					Approximate Interval Between Onset and Death 1987
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. Neurogenic Bladder and Multiple Decubiti DUE TO (OR AS A CONSEQUENCE OF):					1987
		c. Marasmus DUE TO (OR AS A CONSEQUENCE OF):					1990
		d. S/P Rt. AKA Secondary Peripheral Vascular Disease					4/26/95
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Recurrent UTI's Recurrent Pneumonia							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Nomicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER [Signature]				29c. LICENSE NUMBER D 30528		29d. DATE SIGNED (Month, Day, Year) May 7th 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) BALA DUGGIRALA, M.D., 9600 NORTH POINT ROAD, FORT HOWARD, MD. 21052							
MAY 08 1995 [Signature]							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Submitted by: [illegible] 08/08/2011

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Robert Edward Wright				2. DATE OF DEATH MONTH DAY YEAR May 04, 1995		3. TIME OF DEATH 5:00 A M	
4. SOCIAL SECURITY NUMBER 214-66-3285		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 33 YRS.		7. DATE OF BIRTH (Month, Day, Year) Nov. 22, 1961	
9a. FACILITY NAME (If not institution, give street and number) Anne Arundel Medical Center				9b. CITY, TOWN OR LOCATION OF DEATH Annapolis		9c. COUNTY OF DEATH Anne Arundel	
10a. STATE Maryland				10b. COUNTY Anne Arundel		10c. CITY, TOWN OR LOCATION Annapolis	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
10e. STREET AND NUMBER 43 Dean Street, Apt. 1				10f. ZIP CODE 21401		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 3		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Disabled SECURITY GUARD		16b. KIND OF BUSINESS/INDUSTRY Disabled STATE GOVERNMENT			
17. FATHER'S NAME (First, Middle, Last) Phillip I. Wright				18. MOTHER'S NAME (First, Middle, Maiden Surname) Martha E. Washington			
19a. INFORMANT'S NAME (Type/Print) Atha Luvenia Haskins				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 183 Clay Street Annapolis, MD 21401			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory, Inc. 05/05/95		20c. LOCATION — City or Town, State Baltimore, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Dawn F. McDonald				22. NAME AND ADDRESS OF FACILITY Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Respiratory Arrest DUE TO (OR AS A CONSEQUENCE OF): hours b. atypical pneumonia DUE TO (OR AS A CONSEQUENCE OF): 4 wks c. acquired immunodeficiency syndrome DUE TO (OR AS A CONSEQUENCE OF): 2 years d. Approximate Interval Between Onset and Death							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. lymphoma							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Tavani				29c. LICENSE NUMBER D32619		29d. DATE SIGNED (Month, Day, Year) May 04, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 705 Melvin Ave Annapolis Md.							
31. DATE FILED (Month, Day, Year) MAY 08 1995				32. REGISTRAR'S SIGNATURE Julia Davidson-Karl			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13979

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Calvin Samuel Wyatt				2. DATE OF DEATH MONTH May DAY 3rd YEAR 95		3. TIME OF DEATH 17:15 P.M.	
4. SOCIAL SECURITY NUMBER 228-52-7251		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 57 YRS.		7. DATE OF BIRTH (Month, Day, Year) FEB 19, 1938	
9a. FACILITY NAME (If not institution, give street and number) Union Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Balto. City		9c. COUNTY OF DEATH N/A	
10a. STATE Maryland				10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION Baltimore	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER 3100 St. Paul St., Apt. 504			
10f. ZIP CODE 21218				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11th College (1-4 or 5+) 		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Counter Salesman		16b. KIND OF BUSINESS/INDUSTRY Plumbing & Heating Industry			
17. FATHER'S NAME (First, Middle, Last) "Unknown"				18. MOTHER'S NAME (First, Middle, Maiden Surname) Margaret Thomas			
19a. INFORMANT'S NAME (Type/Print) Betty Lou Wyatt				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3100 St. Paul St., Apt. 504 Baltimore, MD 21218			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory, Inc. 05/05/95		20c. LOCATION — City or Town, State Baltimore, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE George E. MacNabb				22. NAME AND ADDRESS OF FACILITY Cremation Society of Maryland 299 Frederick Rd. Baltimore, MD 21228			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Hepato renal syndrome, encephalopathy							
DUE TO (OR AS A CONSEQUENCE OF):							
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
b. Advanced liver cancer							
DUE TO (OR AS A CONSEQUENCE OF):							
c. Chronic alcohol abuse							
DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Coronary artery atherosclerosis							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER A. Hahn M.D.				29c. LICENSE NUMBER AT2438946		29d. DATE SIGNED (Month, Day, Year) May 3rd 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) EL-HABR, Abdallah, UMH 201 E Univ PKW, Baltimore, MD 21218							
31. DATE FILED (Month, Day, Year) MAY 08 1995		32. REGISTRAR'S SIGNATURE Julia [Signature]					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HEALTH DEPARTMENT

TO THE FUNERAL DIRECTOR

2



3



RECEIVED 1964 JUN 10 10 10 AM

95 13980

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) NELLIE BEATRICE WIDENER				2. DATE OF DEATH MONTH APRIL DAY 26 YEAR 1995				3. TIME OF DEATH 9:30AM. M	
4. SOCIAL SECURITY NUMBER 214-18-6472		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 80 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS. HOURS 0 MIN. 0	
9a. FACILITY NAME (If not institution, give street and number) Greater BALTIMORE MEDICAL Center				9b. CITY, TOWN OR LOCATION OF DEATH TOWSON				9c. COUNTY OF DEATH BALTIMORE	
RESIDENCE OF DECEDENT									
10a. STATE Md.		10b. COUNTY BALTIMORE		10c. CITY, TOWN OR LOCATION SPARKS				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 15415 YORK Rd.				10f. ZIP CODE 21152				10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+) —				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOUSEWIFE				16b. KIND OF BUSINESS/INDUSTRY HOME	
17. FATHER'S NAME (First, Middle, Last) Samuel THOMAS				18. MOTHER'S NAME (First, Middle, Maiden Surname) Betty Cole					
19a. INFORMANT'S NAME (Type/Print) ERNEST WIDENER				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15415 YORK Rd. SPARKS, MARYLAND 21152					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Pine Grove Cemetery 4-29				20c. LOCATION — City or Town, State PARKTON MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Robert L. Graves</i>				22. NAME AND ADDRESS OF FACILITY EVANS CHAPEL OF CHIMES 2325 YORK Rd Timonium, Md. 21093					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. COPD, CHF								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
				28d. DESCRIBE HOW INJURY OCCURRED				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Mark Stromberg MD</i>						29c. LICENSE NUMBER D32543		29d. DATE SIGNED (Month, Day, Year) 4/28/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. MARK STROMBERG 7505 OSLER DR. Towson, Md. 21204									
31. DATE FILED (Month, Day, Year) MAY 08 1995				32. REGISTRAR'S SIGNATURE <i>John Andrew Park</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed without having the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95-2527-005

blh ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-725 7/14/95 t.t
Item # 1 Film # G 723 5-8-95 N.A. Per Funeral Home

95 13981

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEASED'S NAME (First, Middle, Last) William Lee Whitfield				2. DATE OF DEATH MONTH DAY YEAR April 30 1995		3. TIME OF DEATH 1948	
4. SOCIAL SECURITY NUMBER 213-86-8705		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (in yrs. last birthday) 27 YRS.		7. DATE OF BIRTH (Month, Day, Year) DEC. 3, 1967	
8. BIRTHPLACE (State or Foreign Country) MARYLAND				9. FACILITY NAME (If not institution, give street and number) 7617 Hackett Avenue		10. CITY, TOWN OR LOCATION OF DEATH Dundalk	
11. COUNTY OF DEATH Baltimore				12. STATE MARYLAND		13. COUNTY N/A	
14. STREET AND NUMBER 4828 PIMLICO ROAD				15. ZIP CODE 21215		16. CITIZEN OF WHAT COUNTRY? USA.	
17. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		18. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		19. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		20. RACE — American Indian, Black, White, etc. Specify: BLACK	
21. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) GED College (1-4 or 5+) College		22. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CONSTRUCTION WORKER		23. KIND OF BUSINESS/INDUSTRY CONSTRUCTION COMPANY			
24. FATHER'S NAME (First, Middle, Last) ROYCE WHITFIELD				25. MOTHER'S NAME (First, Middle, Maiden Surname) LOTTIE MAE McQUEEN			
26. INFORMANT'S NAME (Type/Print) ROYCE WHITFIELD				27. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4828 PIMLICO ROAD, BALTIMORE, MARYLAND 21215			
28. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		29. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MT. ZION CEMETERY		30. DATE 5-6-95		31. LOCATION — City or Town, State BALTIMORE, MARYLAND	
32. SIGNATURE OF FUNERAL SERVICE LICENSEE 				33. NAME AND ADDRESS OF FACILITY JOSEPH H. BROWN JR FUNERAL HOME, P.A. 1913 W. BALTIMORE ST., BALTIMORE, MD. 21223			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → COCAINE AND NARCOTIC INTOXICATION DUE TO (OR AS A CONSEQUENCE OF): a. _____ b. _____ c. _____ d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
34. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		35. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
36. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input checked="" type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide		37. DATE OF INJURY (Month, Day, Year) FOUND: 4-30-95		38. TIME OF INJURY 4:30 P M		39. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
38. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) FOUND: RESIDENCE		39. DESCRIBE HOW INJURY OCCURRED UNKNOWN					
40. LOCATION (Street and Number or Rural Route Number, City or Town, State) 7617 HACKETT AVE. BALTIMORE, MARYLAND							
41. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
42. SIGNATURE AND TITLE OF CERTIFIER 				43. LICENSE NUMBER O.C.M.E.		44. DATE SIGNED (Month, Day, Year) May 01 1995	
45. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201							
46. DATE FILED (Month, Day, Year) MAY 08 1995							
47. REGISTRAR'S SIGNATURE 							

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13982

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARY LEONA WADE				2. DATE OF DEATH MONTH DAY YEAR 05 05 1995				3. TIME OF DEATH 4:30 P. M.					
4. SOCIAL SECURITY NUMBER 219-05-1454		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 74 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) SEPT. 4, 1920		8. BIRTHPLACE (State or Foreign Country) MARYLAND	
9a. FACILITY NAME (If not institution, give street and number) MERIDIAN MULTI-MEDICAL						9b. CITY, TOWN OR LOCATION OF DEATH TOWSON				9c. COUNTY OF DEATH BALTIMORE			
RESIDENCE OF DECEDENT													
10a. STATE MARYLAND		10b. COUNTY BALTIMORE		10c. CITY, TOWN OR LOCATION BALTIMORE				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
10e. STREET AND NUMBER 3308 WASHINGTON BLVD.,						10f. ZIP CODE 21227				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: WHITE					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12TH College (1-4 or 5+) HOMEMAKER				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER				16b. KIND OF BUSINESS/INDUSTRY HOMEMAKING					
17. FATHER'S NAME (First, Middle, Last) LEO KRIMMELBEIN						18. MOTHER'S NAME (First, Middle, Maiden Surname) MARY KESSLER							
19a. INFORMANT'S NAME (Type/Print) RONALD WADE						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3310 WASHINGTON BLVD., BALTIMORE, MD 21227							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium or other place) NEW CATHEDRAL CEMETERY 5/8				20c. LOCATION — City or Town, State BALTIMORE					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Theresa L. Klug</i>						22. NAME AND ADDRESS OF FACILITY HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVENUE-BALTIMORE, MD 21229							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Breast carcinoma													
DUE TO (OR AS A CONSEQUENCE OF):													
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST													
b. DUE TO (OR AS A CONSEQUENCE OF):													
c. DUE TO (OR AS A CONSEQUENCE OF):													
d. DUE TO (OR AS A CONSEQUENCE OF):													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Anemia													
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO									
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Christine Bell-Laffermain</i>						29c. LICENSE NUMBER D33211		29d. DATE SIGNED (Month, Day, Year) 5/6/95					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) CHRISTINE BELL-LAFFERMAIN M.D. Suite 503 1447 York Road, Lutherville MD 21093													
31. DATE FILED (Month, Day, Year) MAY 08 1995 <i>John A. [Signature]</i>													

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If illness is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13983

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) NOREEN RITZ WIEGARD				2. DATE OF DEATH MONTH DAY YEAR May 4 1995		3. TIME OF DEATH 3:05 A M	
4. SOCIAL SECURITY NUMBER 214-12-9416		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 73 YRS.		7. DATE OF BIRTH (Month, Day, Year) March 11, 1922	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) Manor Care-Towson		9b. CITY, TOWN OR LOCATION OF DEATH Towson	
9c. COUNTY OF DEATH Baltimore				10a. STATE Maryland		10b. COUNTY Anne Arundel	
10c. CITY, TOWN OR LOCATION Crofton				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 1906 Layton St.	
10f. ZIP CODE 21114		10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 yrs College (14 or 5+) College (14 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Bookkeeper	
16b. KIND OF BUSINESS/INDUSTRY Transportation		17. FATHER'S NAME (First, Middle, Last) Edward J. Ritz		18. MOTHER'S NAME (First, Middle, Maiden Surname) Margaret N. Kolb		19a. INFORMANT'S NAME (Type/Print) Donna B. Myers	
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1906 Layton St. Crofton Md. 21114		20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gardens of Faith 5-8		20c. LOCATION — City or Town, State Baltimore, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Aspiration Pneumonia DUE TO (OR AS A CONSEQUENCE OF): Dementia Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):		Approximate Interval Between Onset and Death DAYS Years	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>				25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) N/A		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED N/A		28e. PLACE OF INJURY — At home, farm, street, factory, office, building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: In the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER D34952		29d. DATE SIGNED (Month, Day, Year) 5/4/95		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. John T. Eyelius, 5444 Belair Rd. Baltimore, Md.	
31. DATE FILED (Month, Day, Year) MAY 08 1995		31. SIGNATURE OF REGISTRAR 		31. SIGNATURE OF REGISTRAR 		31. SIGNATURE OF REGISTRAR 	

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 10 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 23 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13984

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Angel Weaver</i>				2. DATE OF DEATH MONTH DAY YEAR <i>Apr 29 95</i>		3. TIME OF DEATH <i>1130 P M</i>	
4. SOCIAL SECURITY NUMBER <i>N/A</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) YRS. MONTHS DAYS <i>3 35</i>		7. DATE OF BIRTH (Month, Day, Year) <i>Apr 29 95</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Howard County General Hospital</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Columbia</i>		9c. COUNTY OF DEATH <i>Howard County</i>	
RESIDENCE OF DECEDENT							
10a. STATE <i>Maryland</i>		10b. COUNTY <i>Prince Georges</i>		10c. CITY, TOWN OR LOCATION <i>Temple Hills</i>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <i>2307 Oxon Run Drive</i>				10f. ZIP CODE <i>20748</i>		10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>Black</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>0</i> College (1-4 or 5+) <i>N/A</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>N/A</i>		16b. KIND OF BUSINESS/INDUSTRY <i>N/A</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Siron Maurice Weaver</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Traci Tayana Thompson</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Mr. Siron M. Weaver</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>2307 Oxon Run Drive, Temple Hills, MD 20748</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Columbia Memorial Park 5-8-95</i>		20c. LOCATION — City or Town, State <i>Columbia, MD</i>		20d. DATE <i>5-8-95</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> MO0535				22. NAME AND ADDRESS OF FACILITY <i>Slack Funeral Home, P.A. Ellicott City, Maryland 21043</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <i>Extreme prematurity</i>					
		DUE TO (OR AS A CONSEQUENCE OF):					
		b. <i>Ruptured membranes</i>					
		DUE TO (OR AS A CONSEQUENCE OF):					
		c. <i>Chorioamnionitis</i>					
		DUE TO (OR AS A CONSEQUENCE OF):					
		d.					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Margot Watson MD</i>				29c. LICENSE NUMBER <i>041598</i>		29d. DATE SIGNED (Month, Day, Year) <i>Apr. 29, 95</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>MARGOT WATSON, 11085 LITTLE PATUXENT PKWY, COLUMBIA, MD</i>							
31. DATE FILED (Month, Day, Year) <i>MAY 08 1995</i>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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95 13985

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Lee J. White				2. DATE OF DEATH MONTH 05 DAY 01 YEAR 95				3. TIME OF DEATH 8:00 AM			
4. SOCIAL SECURITY NUMBER 061-22-1101		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 65 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) 08-30-29		8. BIRTHPLACE (State or Foreign Country) NORTH CAROLINA	
9a. FACILITY NAME (If not institution, give street and number) 916 N. Augusta Avenue				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore				9c. COUNTY OF DEATH N/A			
RESIDENCE OF DECEDENT											
10a. STATE Maryland		10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER 916 N. Augusta Avenue				10f. ZIP CODE 21229				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: BLACK			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2 YRS				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) DISTRIBUTION CLERK				16b. KIND OF BUSINESS/INDUSTRY FEDERAL GOVERNMENT			
17. FATHER'S NAME (First, Middle, Last) UNKNOWN				18. MOTHER'S NAME (First, Middle, Maiden Surname) GRACIE LEE BRIM							
19a. INFORMANT'S NAME (Type/Print) ROSELLA WHITE				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 916 N. AUGUSTA AVENUE, BALTO, MD. 21229							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GARRISON FOREST CEMETERY				20c. LOCATION — City or Town, State 5-595 OWINGS MILLS, MD.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY JOSEPH H. BROWN FUNERAL HOME 1913 W. BALTIMORE ST. BALTO, MD. 21223							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cancer of the Stomach DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):										Approximate Interval Between Onset and Death 5 months	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28t. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D24149				29d. DATE SIGNED (Month, Day, Year) 5-1-95			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dorothy Snow, M.D., Staff Physician, 10 N. Greene St., Baltimore, MD 21201											
31. DATE FILED (Month, Day, Year) MAY 08 1995				32. REGISTRAR'S SIGNATURE 							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

TO THE HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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95 13986

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARY A. YODER				2. DATE OF DEATH MONTH DAY YEAR MAY 5, 1995		3. TIME OF DEATH 9:42 p	
4. SOCIAL SECURITY NUMBER 218-78-4470		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) 31 YRS.		7. DATE OF BIRTH (Month, Day, Year) 01 07 64	
9a. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY		9c. COUNTY OF DEATH N/A	
10a. STATE MARYLAND				10b. COUNTY HOWARD		10c. CITY, TOWN OR LOCATION ELKRIDGE	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. ZIP CODE 21227		10f. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) MANAGER		16b. KIND OF BUSINESS/INDUSTRY U.S. GOVERNMENT			
17. FATHER'S NAME (First, Middle, Last) DONALD C. YODER				18. MOTHER'S NAME (First, Middle, Maiden Surname) KIMIE HARA			
19a. INFORMANT'S NAME (Type/Print) DONALD C. YODER				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8724 DOWNIE ROAD-SEVERN, MD. 21144			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MEADOWRIDGE CEMETERY 5/10		20c. LOCATION — City or Town, State ELKRIDGE, MD.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Darryl L. Kaufman</i>				22. NAME AND ADDRESS OF FACILITY RAYMOND C. FINK FUNERAL HOME 21061 426 CRAIN HWY. S.W. GLEN BURNIE, MD.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → SEPSIS DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST SYSTEMIC LUPUS ERYTHEMATOSUS FLARE DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death Two Weeks Two Weeks							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> MD				29c. LICENSE NUMBER M6118		29d. DATE SIGNED (Month, Day, Year) 5/6/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MONICA RAVINDRA SHAH MD 600 N. WOLFE ST-BALTIMORE, MD. 21287							
31. DATE FILED (Month, Day, Year) MAY 08 1995		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



3



95 13987

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Leon Ashman				2. DATE OF DEATH MONTH May DAY 6 YEAR 1995		3. TIME OF DEATH 4:57 P M	
4. SOCIAL SECURITY NUMBER 220-44-6382		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 88 YRS.		7. DATE OF BIRTH (Month, Day, Year) SEPT. 14, 1906	
8. BIRTHPLACE (State or Foreign Country) MARYLAND				9a. FACILITY NAME (If not Institution, give street and number) Manor Care Ruxton		9b. CITY, TOWN OR LOCATION OF DEATH Towson	
9c. COUNTY OF DEATH Baltimore				10a. STATE MARYLAND			
10b. COUNTY BALTIMORE				10c. CITY, TOWN OR LOCATION BALTIMORE			
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 7203 ROCKLAND HILLS DRIVE, APT. #403			
10f. ZIP CODE 21209				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 5+		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) PHYSICIAN		16b. KIND OF BUSINESS/INDUSTRY MEDICAL			
17. FATHER'S NAME (First, Middle, Last) MAX ASHMAN				18. MOTHER'S NAME (First, Middle, Maiden Surname) KATIE BAZINSKY			
19a. INFORMANT'S NAME (Type/Print) DR. MICHAEL N. ASHMAN				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7206 DENBERG ROAD, BALTO., MD. 21209			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MOSES MONTEFIORE-WOODMOOR CEMETERY		20c. LOCATION — City or Town, State BALTIMORE, MD.		20d. DATE 5/8/95	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Sol Levinson</i>				22. NAME AND ADDRESS OF FACILITY Sol Levinson & Bros. 6010 Reisterstown Rd, Baltimore, MD			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → ischemic heart disease DUE TO (OR AS A CONSEQUENCE OF): Approximate interval Between Onset and Death years Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. congestive heart failure short bowel syndrome							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Brian S. Kohnroff MD</i> PHYSICIAN				29c. LICENSE NUMBER D19261		29d. DATE SIGNED (Month, Day, Year) 5/7/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) BRIAN S. KAHNROFF MD 10085 Red Run #305 Owings Mills 21117							
31. DATE FILED (Month, Day, Year) MAY 09 1995							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) SOPHIE S. AYRES				2. DATE OF DEATH MONTH MAY DAY 6 YEAR 1995		3. TIME OF DEATH 3:05 P M	
4. SOCIAL SECURITY NUMBER 213-20-2927		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 71 YRS.		7. DATE OF BIRTH (Month, Day, Year) May 23, 1923	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not Institution, give street and number) Good Samaritan Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore	
9c. COUNTY OF DEATH N/A				10a. STATE Maryland		10b. COUNTY N/A	
10c. CITY, TOWN OR LOCATION Baltimore City				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 4509 Roland Avenue	
10f. ZIP CODE 21210				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2 years				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Legal Secretary		16b. KIND OF BUSINESS/INDUSTRY Judicial	
17. FATHER'S NAME (First, Middle, Last) John Julius Schwartz				18. MOTHER'S NAME (First, Middle, Maiden Surname) Elizabeth Truetle			
19a. INFORMANT'S NAME (Type/Print) George Parkhurst, Esq.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7 North Calvert St., Baltimore, MD 21202			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Green Mount Crematory 5/9		20c. LOCATION — City or Town, State Baltimore, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Martin D. Lawson				22. NAME AND ADDRESS OF FACILITY Mitchell-Wiedefeld Home 6500 York Road, Baltimore, Maryland 21212			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → INTRACRANIAL HEMORRHAGE Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. HYPERTENSION c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death 8 DAYS 50 YEARS							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER MD.				29c. LICENSE NUMBER 045770		29d. DATE SIGNED (Month, Day, Year) MAY 6, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DENNIS ROY IMPERIO GOOD SAMARITAN HOSPITAL 5601 LOCH RAVEN BLVD BALT, MD 21239							
31. DATE FILED (Month, Day, Year) MAY 09 1995				32. REGISTRAR'S SIGNATURE John Andrew K...			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-723 5/9/95 t.t

95 13989

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) KIMBERLY Ann ANTHONY				2. DATE OF DEATH MONTH APRIL DAY 15 YEAR 95		3. TIME OF DEATH 11:35 P.M.	
4. SOCIAL SECURITY NUMBER 216-92-6594		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 28 YRS.		7. DATE OF BIRTH (Month, Day, Year) 6/18/66	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) 2105 BOONE STREET		9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY	
9c. COUNTY OF DEATH NA				10a. STATE Maryland		10b. COUNTY NA	
10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 2527 Barclay Street	
10f. ZIP CODE 21218				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Afro american	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) NA		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) NA		16b. KIND OF BUSINESS/INDUSTRY NA			
17. FATHER'S NAME (First, Middle, Last) Garrison Anthony				18. MOTHER'S NAME (First, Middle, Maiden Surname) Eleanor Addison			
19a. INFORMANT'S NAME (Type/Print) Diane Brown				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2527 Barclay Street Baltimore, Maryland 21218			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Western Star Cemetery 4/25/95		20c. LOCATION — City or Town, State Catonville, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY Jeff Miller Rm 1639 N. Broadway 21213 Baltimore, Maryland			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → NARCOTIC AND ALCOHOL INTOXICATION DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) AT SCENE					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) 4-15-95 FOUND		28b. TIME OF INJURY 10:00 P.M.		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED SUBJECT INGESTED DRUGS AND ALCOHOL		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) FOUND IN HOUSE		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 2105 BOONE ST. BALTIMORE, MD.			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) APRIL 16, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARYDAN A. KOPOLU M.D. 111 Penn Street, Baltimore, Maryland 21201							
31. DATE FILED (Month, Day, Year) MAY 09 1995				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13990

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ARTIST C. BOWERS JR.				2. DATE OF DEATH MONTH MAY DAY 08 YEAR 1995		3. TIME OF DEATH 4:30 a <input type="checkbox"/> m <input checked="" type="checkbox"/>	
4. SOCIAL SECURITY NUMBER 219-16-8198		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 70 YRS.		7. DATE OF BIRTH (Month, Day, Year) 04 29 25	
8. BIRTHPLACE (State or Foreign Country) MARYLAND				9a. FACILITY NAME (If not institution, give street and number) NORTH ARUNDEL HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH GLEN BURNIE	
9c. COUNTY OF DEATH ANNE ARUNDEL				10a. STATE MARYLAND		10b. COUNTY ANNE ARUNDEL	
10c. CITY, TOWN OR LOCATION GLEN BURNIE				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 1902 PAGHAM ROAD	
10f. ZIP CODE 21061				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW 11				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: WHITE				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CABLE SPLICER				16b. KIND OF BUSINESS/INDUSTRY ELECTRICAL			
17. FATHER'S NAME (First, Middle, Last) ARTIST C. BOWERS SR.				18. MOTHER'S NAME (First, Middle, Maiden Surname) DOROTHY BOWERS			
19a. INFORMANT'S NAME (Type/Print) DORIS M. BOWERS				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1902 PAGHAM ROAD—GLEN BURNIE, MD. 21061			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GLEN HAVEN CEMETERY 5/11			
20c. LOCATION — City or Town, State GLEN BURNIE, MD.				21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Darryl L. Kaufman</i>			
22. NAME AND ADDRESS OF FACILITY RAYMOND C. FINK FUNERAL HOME 21061 426 CRAIN HWY. S.W. GLEN BURNIE, MD.				23. PART I. Enter the diseases, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Hemorrhagic shock</i> DUE TO (OR AS A CONSEQUENCE OF): 5 hrs Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. <i>Aorta enteric fistula</i> DUE TO (OR AS A CONSEQUENCE OF): 6 hrs c. DUE TO (OR AS A CONSEQUENCE OF): d.			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO N/A				DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year) 5/11			
28b. TIME OF INJURY M				28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Constantine J. Paduissis</i>				29c. LICENSE NUMBER D18823			
29d. DATE SIGNED (Month, Day, Year) 05/08/95				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) CONSTANTINE J. PADUSSIS M.D. 7310 RITCHIE HWY. GLEN BURNIE, MD.			
31. DATE FILED (Month, Day, Year) MAY 09 1995				32. REGISTRAR'S SIGNATURE <i>John W. Schaefer-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JACK Brooks				2. DATE OF DEATH MONTH May DAY 8 YEAR 1995		3. TIME OF DEATH 11:30 A.M.	
4. SOCIAL SECURITY NUMBER 057-26-3661		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 85 YRS.		7. DATE OF BIRTH (Month, Day, Year) 09-04-09	
9a. FACILITY NAME (If not institution, give street and number) Frederick Villa Nursing Ctr				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH BALTO.	
10a. STATE Md		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Catonsville		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 711 Academy Road				10f. ZIP CODE 21228		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Postal Worker		16b. KIND OF BUSINESS/INDUSTRY US Government			
17. FATHER'S NAME (First, Middle, Last) Sam Brooks				18. MOTHER'S NAME (First, Middle, Maiden Surname) Phyllis Beskins Sadie Unknown			
19a. INFORMANT'S NAME (Type/Print) Phyllis Beskins Beskin				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3030 Ocean Avenue, Brooklyn, N.Y.			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Mt. Ararat Cemetery May 9, 95		20c. LOCATION — City or Town, State Brooklyn, N.Y.		20d. LOCATION — City or Town, State Brooklyn, N.Y.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Peter S. [Signature]				22. NAME AND ADDRESS OF FACILITY Sterling Ashton Funeral Home 736 Edmondson Avenue, Balto, Md. 21228			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cancer of the Pancreas DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death 1 month							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ascites							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER [Signature] M.D.				29c. LICENSE NUMBER D28236		29d. DATE SIGNED (Month, Day, Year) May 8, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dorian S St Martin M.D. 5411 Old Frederick Rd Balto 21229							
31. DATE FILED (Month, Day, Year) MAY 09 1995				32. REGISTRAR'S SIGNATURE [Signature]			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) James R Beamon				2. DATE OF DEATH MONTH May DAY 6 YEAR 1995		3. TIME OF DEATH 1720 M	
4. SOCIAL SECURITY NUMBER 216-50-0531		5. SEX 1 M 2 F		6. AGE (In yrs. last birthday) 47 YRS.		7. DATE OF BIRTH MONTH Sept DAY 28 YEAR 1947	
9a. FACILITY NAME (If not institution, give street and number) St Agnes Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Balto		9c. COUNTY OF DEATH N/A	
RESIDENCE OF DECEDENT							
10a. STATE md		10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION Balto		10d. INSIDE CITY LIMITS? 1 YES 2 NO	
10e. STREET AND NUMBER 602 Loudon Ave				10f. ZIP CODE 21229		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 12-6-1968 12-		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify:		14. RACE — American Indian, Black, White, etc. Specify Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10th College (1-4 or 5+) N/A		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Warehouseman		16b. KIND OF BUSINESS/INDUSTRY Calvert Distillery			
17. FATHER'S NAME (First, Middle, Last) James Roosevelt Beamon				18. MOTHER'S NAME (First, Middle, Maiden Surname) Lenna Bell			
19a. INFORMANT'S NAME (Type/Print) Lenna M. Sherrard				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4709 Sayer Ave Balto, md 21229			
20. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20a. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Garrison Forest vet 5/11/95		20b. LOCATION — City or Town, State Owings Mills, md			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Blodine Wane				22. NAME AND ADDRESS OF FACILITY March R.H. West 4300 Wabash Ave			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → acute meningitis Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST sepsis							Approximate Interval Between Onset and Death 2 days 3 days
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. chronic renal failure, Hypertension, seizure disorder							24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify)					
27. MANNER OF DEATH 1 Natural 5 Pending Investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 YES 2 NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Samir Jarjour M.D.				29c. LICENSE NUMBER DO2062		29d. DATE SIGNED (Month, Day, Year) May-6-95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Samir Jarjour 900 cation ave St. Agnes Hospital BALTIMORE, MD. 21229							
31. DATE FILED (Month, Day, Year) MAY 09 1995				32. REGISTRAR'S SIGNATURE Julia Shuckard Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

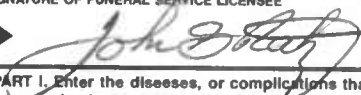
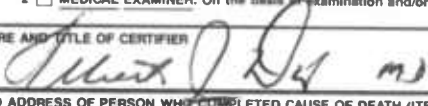
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13993

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last) FREDERICK CHARLES BAKER				2. DATE OF DEATH MONTH DAY YEAR May 3 1995		3. TIME OF DEATH 10:45 am	
4. SOCIAL SECURITY NUMBER 214-03-7955		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 86 YRS.		7. DATE OF BIRTH (Month, Day, Year) APR. 23, 1909	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) Saint Joseph Medical Center		9b. CITY, TOWN OR LOCATION OF DEATH Towson, Maryland	
9c. COUNTY OF DEATH Baltimore				10a. STATE Maryland		10b. COUNTY Baltimore County	
10c. CITY, TOWN OR LOCATION Lutherville				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 109 Belmore Road	
10f. ZIP CODE 21093				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Accountant		16b. KIND OF BUSINESS/INDUSTRY Club, private	
17. FATHER'S NAME (First, Middle, Last) Charles Andrew Baker				18. MOTHER'S NAME (First, Middle, Maiden Surname) Elizabeth M. Parr			
19a. INFORMANT'S NAME (Type/Print) Audrey M.R. Baker				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 109 Belmore Rd. Lutherville, Maryland 21093			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Dulaney Valley MAY 5		20c. LOCATION — City or Town, State Lutherville, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Mitchell-Wiedefeld Home 6500 York Rd. Baltimore, Maryland 21212			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → CEREBRAL HEMORRHAGE DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death 2 DAYS
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PULMONARY EMPHYSEMA							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D 04126		29d. DATE SIGNED (Month, Day, Year) 5/3/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ALBERTO J DIAZ, M.D. 7620 YORK ROAD TOWSON, MARYLAND 21204							
31. DATE FILED (Month, Day, Year) MAY 05 1995							

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10 45 am

May 3, 1992

BAKER

CHALSH

FEDERAL

Baltimore

Towson, Maryland

Johns Hopkins Medical Center

10 45 am

CEREBRAL-EMPHYSEMA

ALUMINUM EMPHYSEMA

Q 04128

ALBERTO L DIAZ MD 1850 YORK ROAD TOWSON, MARYLAND 21204

95 13994

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Charles Elwood Bathgate</u>				2. DATE OF DEATH MONTH DAY YEAR <u>May 6, 1995</u>		3. TIME OF DEATH <u>8:30 A.M.</u>	
4. SOCIAL SECURITY NUMBER <u>215-03-7801</u>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>79</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>April 30, 1916</u>	
8. BIRTHPLACE (State or Foreign Country) <u>Maryland</u>				9a. FACILITY NAME (If not institution, give street and number) <u>514 Castle Drive, Apt B</u>		9b. CITY, TOWN OR LOCATION OF DEATH <u>Baltimore</u>	
9c. COUNTY OF DEATH <u>Baltimore County</u>				10a. STATE <u>Maryland</u>		10b. COUNTY <u>Baltimore County</u>	
10c. CITY, TOWN OR LOCATION <u>Anneslie</u>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <u>514 Castle Drive, Apt B</u>	
10f. ZIP CODE <u>21212</u>				10g. CITIZEN OF WHAT COUNTRY? <u>USA</u>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: <u>White</u>				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>8 years</u> College (1-4 or 5+) <u></u>			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Sales Manager</u>				16b. KIND OF BUSINESS/INDUSTRY <u>Retail Toy Company</u>			
17. FATHER'S NAME (First, Middle, Last) <u>John Edward Bathgate</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Agnes Theresa Hessian</u>			
19a. INFORMANT'S NAME (Type/Print) <u>Mrs. Marietta M. Bathgate</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>514 Castle Drive, Baltimore, MD 21212</u>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) DATE <u>MD Veterans Cem, Garrison</u> <u>5/9</u>			
20c. LOCATION — City or Town, State <u>Garrison, Maryland</u>				21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Martin D. Lawson</u>			
22. NAME AND ADDRESS OF FACILITY <u>Mitchell-Wiedefeld Home</u> <u>6500 York Road, Baltimore, MD 21212</u>				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Acute Pulmonary Edema</u> DUE TO (OR AS A CONSEQUENCE OF): <u>Critical Aortic Stenosis</u> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST c. <u></u> DUE TO (OR AS A CONSEQUENCE OF): d. <u></u>			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u></u>				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year) <u></u>			
28b. TIME OF INJURY <u>M</u>				28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
28d. DESCRIBE HOW INJURY OCCURRED <u></u>				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <u></u>			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <u></u>				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <u>Benjamin K. Yorkoff, M.D.</u>				29c. LICENSE NUMBER <u>D20807</u>			
29d. DATE SIGNED (Month, Day, Year) <u>5/8/95</u>				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>Benjamin K. Yorkoff, M.D., 7401 Osler Drive, Towson, Maryland 21204</u>			
31. DATE FILED (Month, Day, Year) <u>MAY 09 1995</u>				32. REGISTRAR'S SIGNATURE <u>John D. Harker</u>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13995

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Francis Jeroma Beall, Jr.				2. DATE OF DEATH MONTH May DAY 6 YEAR 1995		3. TIME OF DEATH 2:15 M	
4. SOCIAL SECURITY NUMBER 216-20-7003		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 69 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 26, 1925	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) St. Agnes Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore	
9c. COUNTY OF DEATH N/A				10a. STATE Md.		10b. COUNTY Howard	
10c. CITY, TOWN OR LOCATION Dorsey				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 7041 Cedar Ave.	
10f. ZIP CODE 21227				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) N/A				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Accountant		16b. KIND OF BUSINESS/INDUSTRY Railroad	
17. FATHER'S NAME (First, Middle, Last) Francis J. Beall, Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ida Smith			
19a. INFORMANT'S NAME (Type/Print) Francis J. Beall, III				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7041 Cedar Ave., Dorsey, Md. 21227			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Meadowridge Memorial Park 5/10		20c. LOCATION — City or Town, State Elkridge, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Gary L. Kaufman				22. NAME AND ADDRESS OF FACILITY Gary L. Kaufman Funeral Home of Elk., Inc. 5695 Main St., Elkridge, Md. 21227			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastatic small cell lung cancer DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. Pneumonia DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Saukanavachn. S. MD				29c. LICENSE NUMBER D45530		29d. DATE SIGNED (Month, Day, Year) 5-6-95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) S. SIVASAILAM, 900 caton Ave Baltimore MD-21229							
31. DATE FILED (Month, Day, Year) MAY 09 1995				32. REGISTRAR'S SIGNATURE John Andrew Radek			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) CHARLES BUTLER				2. DATE OF DEATH MONTH MAY DAY 5 YEAR 1995		3. TIME OF DEATH 19:36 M	
4. SOCIAL SECURITY NUMBER 579-10-0967A		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 75 YRS.		7. DATE OF BIRTH (Month, Day, Year) 07 31 19	
8. BIRTHPLACE (State or Foreign Country) Washington, DC				9. COUNTY OF DEATH NA			
9a. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY		9c. COUNTY OF DEATH NA	
10a. STATE Maryland		10b. COUNTY NA		10c. CITY, TOWN OR LOCATION Baltimore City		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 3030 McElderry Street				10f. ZIP CODE 21205		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 4/43 - 4/46		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+) NA		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Machinist		16b. KIND OF BUSINESS/INDUSTRY Manufacturing			
17. FATHER'S NAME (First, Middle, Last) Vincent Butler				18. MOTHER'S NAME (First, Middle, Maiden Surname) Aline Haley			
19a. INFORMANT'S NAME (Type/Print) Helen Butler				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3030 McElderry St. Balto, MD 21205			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Garrison Forest Cem. 5/11/95		20c. LOCATION — City or Town, State Owings Mills, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY Unity Funeral Home 108 W. North Ave. Balto, MD 21201			
23. PART I. Enter the disease(s), or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. myocardial infarction DUE TO (OR AS A CONSEQUENCE OF): b. coronary artery disease DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate interval Between Onset and Death 2 years
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> MD				29c. LICENSE NUMBER 10814		29d. DATE SIGNED (Month, Day, Year) 5/9/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Craig S Cornwall 600 N. Welfe Street							
31. DATE FILED (Month, Day, Year) MAY 09 1995		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Esther Brady				2. DATE OF DEATH MONTH MAY DAY 5 YEAR 1995		3. TIME OF DEATH 11:45 P.M.	
4. SOCIAL SECURITY NUMBER 217-05-4908		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 92 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0	IF UNDER 24 HRS. HOURS 0 MIN. 0	7. DATE OF BIRTH (Month, Day, Year) March 29, 1903	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) Charlestown Care Center		9b. CITY, TOWN OR LOCATION OF DEATH Catonsville	
9c. COUNTY OF DEATH Baltimore				10a. STATE Maryland		10b. COUNTY Howard	
10c. CITY, TOWN OR LOCATION Ellicott City				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 3092 Rogers Avenue	
10f. ZIP CODE 21043				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Clerk		16b. KIND OF BUSINESS/INDUSTRY Jewelry Business	
17. FATHER'S NAME (First, Middle, Last) Charles Berlau				18. MOTHER'S NAME (First, Middle, Maiden Surname) Elizabeth			
19a. INFORMANT'S NAME (Type/Print) Thelma Fischer				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14 Evans Grove Road Poquoson, Virginia 23665			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory		20c. LOCATION — City or Town, State 5/6/95 Baltimore Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Luisa Witzke</i>				22. NAME AND ADDRESS OF FACILITY Leroy M. & Russell C. Witzke Funeral Home 1630 Edmondson Ave Catonsville Maryland 21228			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Dehydration Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURRED					
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Gary Applebaum MD</i>				29c. LICENSE NUMBER D34053		29d. DATE SIGNED (Month, Day, Year) May 6, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Gary Applebaum MD 701 Maryland Thoirce Lane 21228							
31. DATE FILED (Month, Day, Year) MAY 09 1995				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13998

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARGARET BARBER				2. DATE OF DEATH MONTH DAY YEAR MAY 5 1995		3. TIME OF DEATH 11:38 A M	
4. SOCIAL SECURITY NUMBER 061-22-4660-A		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 67 YRS.		7. DATE OF BIRTH (Month, Day, Year) Sept 23, 27	
8. BIRTHPLACE (State or Foreign Country) New York				9. FACILITY NAME (If not institution, give street and number) Johns Hopkins Bayview Med		10. CITY, TOWN OR LOCATION OF DEATH BALTO	
11. RESIDENCE OF DECEDENT 10a. STATE MD.				10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION BALTO	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER 2314 FLEET ST.		10f. ZIP CODE 21231	
10g. CITIZEN OF WHAT COUNTRY? USA				11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) N/A	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) BARTENDING				16b. KIND OF BUSINESS/INDUSTRY RESTAURANT			
17. FATHER'S NAME (First, Middle, Last) DAVID O'MARA				18. MOTHER'S NAME (First, Middle, Maiden Surname) CATHERINE EVANS			
19a. INFORMANT'S NAME (Type/Print) BARBARA LINVILLE				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7122 GREENWOOD AVE BALTO 21206 MD.			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) METRO Crematory 5/8		20c. LOCATION — City or Town, State BALTO MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY DELLA NOCE + SONS FUNERAL HOME 322 S. HIGH ST. BALTO 21202 MD.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Brain infarct DUE TO (OR AS A CONSEQUENCE OF): a. Brain infarct b. Following right carotid endarterectomy c. Following right carotid endarterectomy d. Following right carotid endarterectomy Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> ODA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) N/A		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED N/A		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) N/A		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) N/A			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> MD				29c. LICENSE NUMBER P08325		29d. DATE SIGNED (Month, Day, Year) May 8 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dept of Neurology Johns Hopkins Bayview							
31. DATE FILED (Month, Day, Year) MAY 09 1995		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the death certificate. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) THOMAS MARTIN BUCKSHAW JR.				2. DATE OF DEATH MONTH DAY YEAR MAY 05, 1995		3. TIME OF DEATH 23:59 P M					
4. SOCIAL SECURITY NUMBER 159-54-6072		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 31 YRS.		7. DATE OF BIRTH (Month, Day, Year) 01-25-1964		8. BIRTHPLACE (State or Foreign Country) PENNSYLVANIA			
9a. FACILITY NAME (If not institution, give street and number) 9975 HARVEST DR.				9b. CITY, TOWN OR LOCATION OF DEATH N/A			9c. COUNTY OF DEATH FREDERICK				
10a. STATE MARYLAND		10b. COUNTY FREDERICK		10c. CITY, TOWN OR LOCATION N/A			10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				
10e. STREET AND NUMBER 9975 HARVEST DRIVE				10f. ZIP CODE 21702		10g. CITIZEN OF WHAT COUNTRY? U.S.A.					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: WHITE				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SELF EMPLOYED		16b. KIND OF BUSINESS/INDUSTRY LANDLORD							
17. FATHER'S NAME (First, Middle, Last) THOMAS M. BUCKSHAW SR.				18. MOTHER'S NAME (First, Middle, Maiden Surname) MARGARET A. GUNTER							
19a. INFORMANT'S NAME (Type/Print) ROBINSON-LYTTLE F. HOME				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 36 NORTH SEVENTH ST. INDIANA, PA. 15701.							
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) LUTHER CHAPEL CEMETERY 5/95		DATE INDIANA, PA.		20c. LOCATION — City or Town, State					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>William K. Davis III</i>				22. NAME AND ADDRESS OF FACILITY HENRY W. JENKINS & SONS CO. 4905 YORK RD. BALTO., MD. 21212.							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>INTRACRANIAL SHOTGUN WOUND</u> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. _____ DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 5 ? 95		28b. TIME OF INJURY UNK M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED SUBJECT SHOT SELF			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) RESIDENCE				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 9975 HARVEST DR. FREDERICK MD							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <i>David A. Bucksh</i>				29c. LICENSE NUMBER OCME		29d. DATE SIGNED (Month, Day, Year) MAY 06, 1995					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Margaret A. Korowick 111 Penn Street, Baltimore, Maryland 21201											
31. DATE FILED (Month, Day, Year) MAY 09 1995				32. REGISTRAR'S SIGNATURE <i>John Bucksh</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR OTHER FACILITY: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

11-26-1963 7:10 PM

ITEMS: 23 PART I, 27, PER MEO FILM G-724 6/5/95 t.t

95 14000

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) BREON				2. DATE OF DEATH MONTH APRIL DAY 23 YEAR 95				3. TIME OF DEATH 9:36 A	
4. SOCIAL SECURITY NUMBER 217-43-3990		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) YRS. 2 MONTHS 15 DAYS 15 HOURS 15 MIN.		7. DATE OF BIRTH (Month, Day, Year)		8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not institution, give street and number) JOHNS HOPKINS HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY				9c. COUNTY OF DEATH NA	
10a. STATE Maryland				10b. COUNTY NA		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 821 Bonaparte Avenue				10f. ZIP CODE 21218		10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Afro-American			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) NA College (1-4 or 5+) NA				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) NA		16b. KIND OF BUSINESS/INDUSTRY NA			
17. FATHER'S NAME (First, Middle, Last) Anthony Bull				18. MOTHER'S NAME (First, Middle, Maiden Surname) Tyra Moniss					
19a. INFORMANT'S NAME (Type/Print) Anthony Bull				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 821 Bonaparte Avenue Baltimore, Maryland 21218					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, funeral home, etc.) Louisa Park Cemetery 4-29-95		20c. LOCATION — City or Town, State Baltimore, Maryland					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Jeff Miller F/H PC 1639 N. Broadway 21213					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → SUDDEN INFANT DEATH SYNDROME DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER 						29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) APRIL 25, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) M 111 Penn Street, Baltimore, Maryland 21201									
31. DATE FILED (Month, Day, Year) MAY 09 1995		32. REGISTRAR'S SIGNATURE 							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

